YOUR BENEFIT SUMMARY

Retiree Medical and Dental Benefits

JUNE 2019
About this Summary

This Summary Plan Description (SPD) provides a concise description of the Retiree Medical Program (the Retiree Medical Plan) and the Retiree Dental Plan. This SPD is intended to help you understand your benefits, how the Retiree Medical Plan and Retiree Dental Plan 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 Retiree Medical Plan and Retiree Dental Plan, and it is not intended to be a full statement of the official plan documents. In the event of a discrepancy between this SPD and the official plan documents, the applicable official plan document(s) will govern and the Plan Administrator has the full discretion to interpret those documents.

While the Company intends to continue the Plans 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 the Defined Terms section on page 64 for the meanings of certain capitalized terms used in this summary.
Corteva’s retiree medical and dental benefits offer comprehensive and robust programs to eligible retirees, Survivors and dependents to help keep you healthy, save you money and protect you and your family.

CONTENTS AT A GLANCE

Eligibility and Enrollment ........................................................................................................ 4
Retiree Medical Program ........................................................................................................... 12
Retiree Dental Plan .................................................................................................................... 41
Claiming Benefits ..................................................................................................................... 52
When Coverage Ends .............................................................................................................. 61
Defined Terms .......................................................................................................................... 64
Administrative Information ....................................................................................................... 65
Contacts .................................................................................................................................. 68
Contacts for Appeals ................................................................................................................ 70
Eligibility and Enrollment

Your eligibility for the coverage described in this summary depends on your:

- employment status,
- company,
- hire date,
- years of continuous service, and
- age.

Who Is Eligible

You are eligible for the Retiree Medical Program Retiree Medical Plan and/or the Retiree Dental Plan if you are a retiree or Survivor from a Company that has adopted the Plan for former employees.

If you have questions regarding your eligibility, contact Corteva Connection.

Newly retiring employees must meet the eligibility requirements outlined in the table below. In addition, effective November 30, 2018, active employees also must have reached age 50 or older as of November 30, 2018, to be eligible for Retiree Medical Program or Retiree Dental Plan benefits.

<table>
<thead>
<tr>
<th>Company</th>
<th>Eligibility Requirements</th>
</tr>
</thead>
</table>
| Corteva (Including Puerto Rico subsidiaries) | You qualify for **Retiree Medical Program** and **Retiree Dental Plan** coverage if you were eligible to receive a Normal, Early, or Optional pension from the Corteva Pension and Retirement Plan when your employment terminated, which requires that you were:  
  - hired before January 1, 2007*; and  
  - age 50 or older with 15 or more years of service at termination of employment; or  
  - age 45 or older and received an Optional pension at termination of employment due to lack of work.  
  Employees who transferred to an affiliated Company with a similar pension plan after attaining 15 or more years of service who retire after reaching age 50 or older are also eligible. |
| Pioneer Hi-Bred International, Inc. (Including Puerto Rico) | You qualify for **Retiree Medical Program** and **Retiree Dental Plan** coverage if you were:  
  - hired before January 1, 2010*; and  
  - age 55 or older at retirement with five or more years of service at retirement; or  
  - age 50 or older with five or more years of service at termination of employment due to lack of work. |
| Solae                                        | You qualify for **Retiree Medical Program coverage up to age 65** if you were:  
  - hired before January 1, 2013*;  
  - age 55 or older with two or more years of service at retirement.  
  **Retiree Dental Plan coverage does not apply.** |
| Danisco                                      | Note that Danisco retirees receive post-employment medical continuation coverage (COBRA) in the Medical Plan instead of the Retiree Medical Program, with coverage ending at age 65. For eligibility details, refer to the Flexible Benefits Handbook summary. |

Questions?

If you have questions about the rules for eligibility and how to enroll, contact Corteva Connection at 1-800-775-5955.
Company | Eligibility Requirements
--- | ---
Genencor | You qualify for Retiree Medical Program coverage if you were:
▪ formerly covered by the Genencor International Indiana, Inc. Union Retiree Plan; and
▪ Met the eligibility criteria specific to that Plan at retirement.
Please contact Corteva Connection at 1-800-775-5955 to find out if you qualify.
Retiree Dental Plan coverage does not apply

MECS, Inc. | You qualify for Retiree Medical Program coverage if were:
▪ hired before May 1, 2002* and
▪ at least age 55 when you retired with at least 10 years of service.
Retiree Dental Plan coverage does not apply

* You must have no break in service after the hire dates shown in the above chart in order to remain eligible.

Coverage for Medicare-Eligible Retirees and Survivors
Once you or your dependent is eligible for Medicare, your Retiree Medical Plan coverage will change to a Company-funded Health Reimbursement Arrangement (HRA). You must enroll in an individual medical or dental program through Via Benefits to receive the HRA. See "After Becoming Eligible for Medicare" on page 8 for more information.

Eligible Dependents
For the Retiree Medical Program and Retiree Dental Plan, you may cover:
▪ your legal spouse;
  ▫ Must have been married on your last day of active employment (or on January 1, 2008 if you were already retired).
▪ your children who meet these criteria:
  ▫ The child is either:
    ▪ your biological child;
    ▪ your stepchild from your current marriage;
    ▪ your adopted child (including a child legally placed with you for adoption);
    ▪ your foster child; or
    ▪ your ward, where you are the court-appointed, 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 your federal tax dependent and was certified as disabled by the Retiree Medical Plan's Claims Administrator before the child's 26th birthday and continues to be disabled. You will be required to periodically substantiate your dependent’s continued eligibility by submitting documentation as requested by the Claims Administrator; and
      ▪ you claim the child as your dependent on your federal income tax return.

If Your Spouse Is Eligible for Other Medical Coverage
If your spouse is eligible for medical coverage through their employer and their individual premium cost for the lowest-priced employee-only coverage available is less than $100 per month, they must elect primary coverage through their employer. Spouse coverage under the Retiree Medical Program will be secondary.
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 spouses and your spouse if you are legally separated are not eligible for coverage, even if you are ordered by the court to provide coverage.

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

You must notify Corteva Connection at 1-800-775-5955 if an enrolled dependent is no longer eligible. Your dependent may be eligible for COBRA continuation coverage if you notify the Plan within 60 days of the date the dependent becomes ineligible. The Plan Administrator may take action to recover the value of any benefits provided while the dependent was ineligible.

**If Both You and Your Spouse Are Eligible for Coverage**

*If both you and your spouse are eligible for coverage, you can cover your spouse as a dependent, or your spouse can elect separate coverage. You or your spouse can’t be covered as both a retiree and a dependent under the Retiree Medical Plan or Retiree Dental Plan.*

**Your Children**

*If both you and your spouse are eligible for coverage, only one of you can cover your eligible child as a dependent. 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 Corteva Legal Department or its designee. For a copy of the QMCSO procedure, contact the Plan Administrator or Corteva Connection at 1-800-775-5955.

**Dependent Verification**

The Company is committed to following Plan requirements and managing the cost of our health plans 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

You are automatically enrolled in the Retiree Medical Plan and/or Retiree Dental Plan when you first become eligible, as long as you are participating in a medical and/or dental plan sponsored by the Company immediately prior to becoming eligible. If you had declined other medical or dental coverage, you will need to contact Corteva Connection to enroll in the Retiree Medical Plan and/or Retiree Dental Plan within 31 days of becoming eligible.

Important information about opting out of coverage can be found under “When You Drop Coverage” on page 10. We strongly encourage you to read that information.

You can change your elections:

- At retirement,
- During the Annual Enrollment period, each fall and
- As necessary, to drop coverage or to add a new dependent.

See “Changing Your Coverage” on page 9 for information about making changes.

Electing COBRA Coverage Instead of Retiree Coverage

If you choose, you can elect to continue your medical and dental coverage at retirement through COBRA (generally for up to 18 months), instead of enrolling in the Retiree Medical Plan and Retiree Dental Plans. If you want to elect COBRA coverage, you must notify Corteva Connection at retirement. You cannot elect COBRA and later switch to Retiree Medical Plan and Retiree Dental Plan coverage. Electing COBRA coverage instead of retiree coverage is permanent and irrevocable (except for Solae employees whose employment ended under the Career Transition Program).

PRE-MEDICARE COVERAGE—AUTOMATIC ENROLLMENT

If you are a newly eligible retiree, you and your covered dependents who are not yet eligible for Medicare will be automatically enrolled in the Retiree Medical Plan and/or Retiree Dental Plan as shown below. These Plans provide coverage until you are eligible for Medicare.

<table>
<thead>
<tr>
<th>If you reside in...</th>
<th>You will automatically be enrolled in...</th>
</tr>
</thead>
</table>
| Mainland U.S., excluding retirees from Solae and MECS | • The Retiree Medical Plan Core or Premium Saver Option that most closely resembles your active employee option.  
• The Retiree Dental Plan Standard Option. The High Option is not available through the Retiree Dental Plan. If you wish to elect the Limited Option, you must call Corteva Connection to enroll. (Note that the Retiree Dental Plan is not available to former employees of Genencor or Danisco, as noted under “Who Is Eligible” on page 4.) |
| Puerto Rico | • The Retiree Medical Plan Alternative Coverage Option with Triple S as the carrier.  
• The Retiree Dental Plan Standard Option. The High Option is not available through the Retiree Dental Plan. If you wish to elect the Limited Option, you must call Corteva Connection to enroll. |
| Hawaii | • The Retiree Medical Plan Core Option. HMSA is not available through the Retiree Medical Plan. If you wish to elect the Premium Saver Option, you must call Corteva Connection to enroll.  
• The Retiree Dental Plan Standard Option. The High Option is not available through the Retiree Dental Plan. If you wish to elect the Limited Option, you must call Corteva Connection to enroll. |
| Any state and you are a retiree from Solae or MECS | • The Retiree Medical Plan Alternative Coverage Option with Highmark BCBS as the carrier.  
• You are not eligible for Retiree Dental Plan coverage as a retiree. |
Your coverage continues at the same coverage level (you only, you plus spouse, you plus child[ren] or you plus family) that you elected as an active employee.

If you want to change your coverage option, coverage level or decline coverage, contact Corteva Connection at 1-800-775-5955. Keep in mind, if you elect to decline coverage, you cannot add coverage at a later date unless you lose eligibility for coverage under another group plan. See “Changing Your Coverage” on page 9 for more information.

AFTER BECOMING ELIGIBLE FOR MEDICARE

This section describes how coverage changes once you or your covered dependent becomes eligible for Medicare (usually at age 65 or earlier if disabled). Other covered family members who are not yet eligible for Medicare remain on the pre-Medicare coverage.

There are important actions that you must take within 60 days of becoming eligible for Medicare.

For the Medicare-eligible individual:

- **Pre-Medicare coverage** in the Retiree Medical Plan and Retiree Dental Plan ends the first of the month in which they become eligible for Medicare or reach age 65 (whichever occurs first).
  - Individuals who become eligible for Medicare due to a disability (other than End Stage Renal Disease), before age 65, must notify Corteva Connection on 1-800-775-5955. They may not continue pre-Medicare coverage in the Retiree Medical Plan and Retiree Dental Plan once they are eligible for Medicare.
  - Individuals who become eligible for Medicare at age 65 will automatically have their pre-Medicare Retiree Medical Plan and Retiree Dental Plan coverage end.

- **Medicare becomes their primary coverage. To enroll in Medicare:**
  - Contact the Social Security Administration three months before you turn age 65 to enroll in parts A (hospital) and B (medical/surgical) of Medicare.
  - Information on Medicare can be found at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

The Company provides annual Health Reimbursement Arrangement (HRA) account funding for Medicare-eligible retirees from Corteva (including Puerto Rico subsidiaries), Pioneer (including Puerto Rico subsidiaries), Genencor, and MECS. See “After You Become Eligible for Medicare” on page 39 for more information on the HRA.

- In order to receive the HRA, the Medicare-eligible covered individual must purchase an individual health plan through Via Benefits, the Company’s official Claims Administrator for the HRA portion of the Plan. Enrollment is required within 60 days of becoming eligible for Medicare. You may need to first have Medicare Part A and Part B to enroll in a plan through Via Benefits. Once enrolled in Medicare Part A and Part B and before the 60-day enrollment deadline, contact Via Benefits on 1-855-535-7140 to enroll in an individual health plan.

- The Via Benefits Benefit Advisors (BA) will help you purchase an individual health plan to qualify to receive a Health Reimbursement Arrangement (HRA) account from Corteva.
  - If you participated in the Plan’s medical coverage prior to becoming eligible for Medicare, you will need to purchase either a Medicare Supplement or Medicare Advantage individual insurance plan from Via Benefits in order to receive the HRA. Purchase of a dental plan or prescription drug plan is optional.
  - If you participated in the Plan’s dental coverage (but not medical coverage) prior to becoming eligible for Medicare, you must enroll in an individual dental insurance plan from Via Benefits in order to receive the HRA. Purchase of a medical or prescription drug plan is optional.
If a medical plan is not purchased through Via Benefits within 60 days of becoming eligible for Medicare:

- For you (the retiree/Survivor)—your coverage will be permanently and irrevocably cancelled. You will not receive an HRA account and your dependents coverage will also be permanently cancelled, even if they are not yet eligible for Medicare.
- For your dependent—your dependent’s coverage will be permanently and irrevocably cancelled, along with the HRA account funding. Coverage for you and your other covered dependents (if any) will continue.
- Refer to ‘When You Drop Coverage” on page 10 for additional details.

**If You Live Outside of the U.S. and are eligible for the HRA**

Via Benefits does not sell insurance plans in Puerto Rico or outside of the U.S. Therefore, the requirement to buy a medical or dental plan through Via Benefits is waived while you live outside the U.S. mainland. You may use your HRA to reimburse your qualifying expenses or premiums for an individual medical or dental plan you purchase locally.

**Paying for Coverage**

The premiums for the Retiree Medical Plan and Retiree Dental Plan are normally deducted from your pension payment, if possible.

If your pension payment does not cover the amount of the premium, or if you have elected to defer your pension payments, you will be responsible for making premium payments. Please contact Corteva Connection to make payment arrangements (including automatic debits from your checking or savings account).

**When Coverage Begins**

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

**Newly Eligible Participants**

When you retire, your active employee medical and dental coverage continues through the end of the month. Your participation in the Retiree Medical Plan and/or Retiree Dental Plan begins on the 1st of the month following your termination of employment. For example, if you retire May 15th, your active employee coverage would end on May 31st and your retiree coverage would begin on June 1st.

If you add a newly eligible dependent (such as a new child or step child), their coverage becomes effective retroactive to the date they became eligible if you call Corteva Connection within 31 days. Otherwise, their coverage will start on the 1st of the month following your call.

**Annual Enrollment**

Annual Enrollment is normally held during the fall of each year. Any election changes made during the Annual Enrollment period will become effective as of January 1 of the following year. For example, if you make changes during Annual Enrollment in the fall of 2019, those changes are effective on January 1, 2020.

**Changing Your Coverage**

You may change your benefits elections when necessary by contacting Corteva Connection. You may do any of the following:

- Change your Retiree Medical Plan coverage option during Annual Enrollment (for example, changing from the medical Core Option to the Premium Saver Option)
- Change the level of your coverage (you only, you plus spouse, you plus child[ren] or you plus family)
- Add a newly eligible dependent child to medical or dental coverage
- Permanently drop coverage for yourself and/or one or more named dependents
- Re-enroll yourself or a covered dependent in the Retiree Medical Plan or Retiree Dental Plan within 60 days of losing eligibility for your coverage in another group plan, after having been continuously covered by another group plan while you were not covered in the Retiree Medical Plan or Retiree Dental Plan
- Change from the Retiree Dental Plan's Standard Option to the Limited Option, provided you have participated in the Standard Option for at least 12 months as a retiree or Survivor, or elect the Limited Option within 31 days of retirement

**When the Change Is Effective**
All changes in your benefits elections will become effective on the first day of the month following the date you report the change. If you are re-enrolling in coverage, proof of loss of other group health coverage is required.

**When You Drop Coverage**
Your coverage ends on the last day of the month in which you discontinue coverage.

A decision to decline post-employment medical or dental coverage for yourself or your dependents is permanent and cannot be changed. If you decline medical or dental coverage as a retiree or Survivor for yourself, coverage for your dependents also ends. You may, however, decline coverage for your dependents and continue coverage for yourself.

Example 1: You have coverage for yourself and your spouse. You become eligible for Medicare and want to drop your coverage (or you lose your coverage by not purchasing an individual plan through Via Benefits as described under “After You Become Eligible for Medicare” on page 39). If you drop your coverage, the Retiree Medical Plan coverage for you and your spouse will permanently and irrevocably end and your HRA account will be closed.

Example 2: You have coverage for yourself and your spouse. You can drop coverage for your spouse (permanently and irrevocably) and continue your Retiree Medical Plan and Retiree Dental Plan coverage.

If you decline coverage for yourself, you cannot later enroll in the Retiree Medical Plan or Retiree Dental Plan unless you were continuously covered in another group health plan while you were not enrolled and you lose eligibility for coverage under another employer or a government plan. Similarly, if you decline coverage for your spouse, you can only re-enroll your spouse if he/she loses eligibility for other group coverage. Loss of coverage cannot be because of nonpayment of premiums. Re-enrollment must occur with 31 days of the date group coverage ended for you or your spouse.

Example 3: You have coverage for yourself and your spouse. Your spouse takes a job with another company offering group health coverage. You can drop coverage and re-enroll when your spouse terminates employment with the other company (losing eligibility for the other company’s group health plan).

**What Happens If …**

**You Are Rehired by the Company**
If you are eligible for Retiree Medical Plan and/or Retiree Dental Plan coverage and are rehired by the Company, you have the option to temporarily elect to end your retiree coverage while you are participating in the active employee medical and/or dental plans. You can re-enroll in retiree coverage when you lose eligibility for the Company’s active employee group medical and/or dental plans, such as when you terminate employment.
You Become Eligible for Medicare or Reach Age 65
Once you or your dependent is eligible for Medicare, your Company medical coverage will end. You may be eligible for a Company-funded Health Reimbursement Arrangement (HRA) when you enroll in an individual medical or dental program through Via Benefits. See “After Becoming Eligible for Medicare” on page 8 for more information.

Your Spouse Is Medicare-Eligible and You Are Not
In the case of a “split family” where one person is eligible for Medicare and one or more is not, the non-Medicare-eligible individual(s) will be covered under the Pre-Medicare option; the Medicare-eligible individual(s) must be enrolled in Medicare coverage. He or she may also be eligible for a Company-funded Health Reimbursement Arrangement (HRA) if they enroll in an individual medical or dental program through Via Benefits. See “After Becoming Eligible for Medicare” on page 8 for more information.

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 Corteva Connection at 1-800-775-5955 if an enrolled dependent no longer meets the Plan’s definition of an eligible dependent.

▪ Your dependent will be eligible for COBRA continuation coverage if you notify the Plan within 60 days of the date the dependent becomes ineligible.

▪ If a Company plan pays any benefits while your dependent was ineligible, the Plan Administrator may take action to recover the value of the benefits provided while the dependent was ineligible.

You or a Dependent’s Other Employer Coverage Ends or Changes
If you or your spouse have medical or dental coverage from another employer's plan and that coverage ends, you can enroll yourself and/or your spouse for Company medical or dental coverage, if you are eligible. See “Changing Your Coverage” on page 9.

You Die
If you meet the requirements to be eligible for Survivor benefits as defined under the Pension and Retirement Plan before your death, your designated Survivors may be eligible for continued coverage under the Retiree Medical Plan and/or Retiree Dental Plan. See the rules for Survivor benefits under the “Corteva Pension and Retirement Plan” summary for more information about eligibility requirements.

Otherwise, their coverage ends at the end of the month of your death. Your surviving dependents may be eligible for COBRA continuation of coverage, which allows your dependents to continue coverage for up to 36 months.

Contact your Corteva Connection at 1-800-775-5955 for details.

Who Is a Survivor?
Your Survivor is the person (or people) who receive the remaining value of your vested Pension Plan benefit when you die.

Your spouse is typically your Survivor. In some cases, Survivor benefits can be made payable to your child, who may qualify for Plan coverage up to the age of 21.
Retiree Medical Program

The Retiree Medical Program (the “Retiree Medical Plan”) is designed to provide quality pre-Medicare coverage to retirees, Survivors and covered dependents. The program encourages preventive care, promotes overall wellness and protects you from the high cost of medical and prescription drug expenses. Medicare-eligible participants may qualify to receive annual Health Reimbursement Arrangement (HRA) account contributions from the Company while purchasing an individual medical plan to supplement Medicare.

Questions?

If you have questions about your coverage that are not answered here, contact the carrier for the plan you are enrolled in. See the Contacts section, on page 68.

SECTION CONTENTS

Highlights – Pre-Medicare Options .............................................................. 13
Pre-Medicare Options ................................................................. 14
   If You Waive Coverage .......................................................... 14
Cost of Coverage ........................................................................ 14
How Coverage Works .................................................................. 15
What Is Covered ........................................................................... 22
What Is Not Covered .................................................................. 34
Using a Health Savings Account (HSA) ........................................... 37
After You Become Eligible for Medicare ........................................ 39
   Highlights .................................................................................. 39
   How Corteva Funds the HRA ..................................................... 40

Eligibility and Enrollment

For information about eligibility and enrollment, please see “Eligibility and Enrollment” on page 4.
Highlights—Pre-Medicare Options
The Retiree Medical Plan includes two medical options available in the mainland U.S. and Hawaii: the Core and Premium Saver Options. An outline of these options is shown below. Read the full summary for more details.

If you live in Puerto Rico or receive benefits from Solae or MECS, alternative coverage applies. In Puerto Rico, the Company offers an Alternative Coverage Option administered and described in materials provided by Triple S. For Solae and MECS participants, the Company offers an Alternative Coverage Option insured and described in materials provided by Highmark BCBS. For information on the Alternative Coverage Options, call Triple S or Highmark BCBS at the numbers listed in the Contacts section on page 68.

<table>
<thead>
<tr>
<th>Core Option</th>
<th>Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Care Benefits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong> (annual amount, combined for medical and prescription drug claims)</td>
<td>$1,400 for you only coverage</td>
</tr>
<tr>
<td></td>
<td>$2,000 for other coverage levels</td>
</tr>
<tr>
<td><strong>Preventive Care</strong> (see your medical carrier for a list of covered services)</td>
<td>100% paid, no deductible</td>
</tr>
<tr>
<td><strong>Coinsurance for medical services</strong></td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>• Office visits</td>
<td></td>
</tr>
<tr>
<td>• Mental health care</td>
<td></td>
</tr>
<tr>
<td>• Chiropractic care ($1,000 annual limit)</td>
<td></td>
</tr>
<tr>
<td>• Labs and X-Rays</td>
<td></td>
</tr>
<tr>
<td>• Hospitalization</td>
<td></td>
</tr>
<tr>
<td>• Surgery</td>
<td></td>
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<tr>
<td><strong>Prevention Cost Sharing</strong></td>
<td></td>
</tr>
<tr>
<td>The deductible is waived for medications on the preventive medication list (see “Preventive Medications” on page 32)</td>
<td></td>
</tr>
<tr>
<td>• Retail benefits apply to a single fill up to a 30-day supply;</td>
<td></td>
</tr>
<tr>
<td>• Mail-Order benefits apply to a single fill of up to a 90-day supply.</td>
<td></td>
</tr>
<tr>
<td>• Additional information regarding prescription drugs appears under “Prescription Drugs” on page 30.</td>
<td></td>
</tr>
</tbody>
</table>

**Generic**
No charge after deductible
No charge after deductible

**Brand Formulary (Preferred)**
You pay 25% after deductible; $125 maximum* per fill
You pay 25% after deductible; $125 maximum* per fill

**Brand Non-Formulary (Non-Preferred)**
You pay 45% after deductible; $250 maximum* per fill
You pay 45% after deductible; $250 maximum* per fill

**Maintenance medications after second fill at retail pharmacies**
You pay 45% after deductible; no maximum
You pay 45% after deductible; no maximum

**Out of Pocket Maximum** (annual amount, combined for medical and prescription drug claims)

| Each Person | $5,000 | $6,000 |
| All Covered Family Members Combined | $10,000 | $12,000 |

* Rx maximum coinsurance amounts are per prescription
Your Deductible Applies to Medical and Prescription Drug Services
The Plan uses a combined deductible for medical, prescription drug and mental health/chemical dependence care. But, there are separate deductibles for in-network care and out-of-network care.

Pre-Medicare Options
In the mainland U.S. and Hawaii, you can choose between two options:
- Core Option
- Premium Saver Option
You also have the option to waive coverage. (Waiving coverage is permanent and irrevocable – see below.)
Retiree Medical Plan claims administration and preferred provider networks vary based on where you live.
- The medical Claims Administrators include Aetna and Highmark BCBS.
- Prescription drug claims are administered through CVS Caremark
- Mental health and chemical dependency coverage is provided through ComPsych.
If you participate in an Alternative Coverage Option (for Solae, MECS and residents of Puerto Rico), contact your medical carrier for prescription coverage information. In the event that the Retiree Medical Plan changes carriers, you will be notified and this summary will be updated.

Contact information for the Claims Administrators (also referred to as “carriers”) is provided under “Administrative Plan Details” on page 66.

If You Waive Coverage
If you decline post-employment medical or dental coverage for yourself or your dependents, you cannot change this election at a later date unless you lose eligibility for other group health coverage. See “When You Drop Coverage” on page 10 for details.

Cost of Coverage
If you participate in the Retiree Medical Plan prior to becoming eligible for Medicare or turning age 65, the monthly cost of your coverage will be as follows:

<table>
<thead>
<tr>
<th>2019 Standard Monthly Premium Rates for Retirees</th>
<th>Core Option</th>
<th>Premium Saver Option</th>
<th>Alternative Coverage Option for Solae, MECS and Puerto Rico</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Level</td>
<td>Core Option</td>
<td>Premium Saver Option</td>
<td>Call Corteva Connection 1-800-775-5955 for Premium Information and Medical Options</td>
</tr>
<tr>
<td>You Only</td>
<td>$215</td>
<td>$170</td>
<td></td>
</tr>
<tr>
<td>You + Spouse</td>
<td>$430</td>
<td>$340</td>
<td></td>
</tr>
<tr>
<td>Other coverage levels</td>
<td>Call Corteva Connection for rates</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your premiums may differ from those shown above based on various factors such as your age, service at retirement and if an early retirement proration factor applies. You will be provided with a personalized statement of premium on an annual basis following the Annual Enrollment period.

Working Spouse Rule
If your spouse is eligible for medical coverage through their employer and their premium for individual employee-only coverage is less than $100 per month, they must purchase coverage through their employer. Spouse coverage under the Retiree Medical Program, if they are enrolled, will be secondary.
As a reminder, in 2003, the Company placed a limit on the amount of premium subsidy that will be provided to Retiree Medical Plan participants. This limit has not been reached. After the limit is reached, in the future, the Company will pass the full annual cost increase on to participants.

Prorated Premiums and HRA Funds— for Corteva and Genencor participants only

Early retirees who terminated employment on or after January 1, 1994 pay a higher monthly premium than those shown in the table above. The Company contribution for medical coverage is prorated based on your age and service at the time of retirement (i.e. when you terminate from the Company). Example: If you retired early and had a 50% reduction factor at the time you terminated employment, you would pay the premium shown in the table plus 50% of the standard Company share of the premium. This factor will also be applied to any Survivor’s medical premium and any HRA funds that you or your dependents receive after becoming eligible for Medicare. Contact Corteva Connection to verify your reduction factor.

How Coverage Works

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Premiums</th>
<th>Deductible</th>
<th>Out-of-Pocket Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Option</td>
<td>Higher</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>Premium Saver Option</td>
<td>Lower</td>
<td>Higher</td>
<td>Higher</td>
</tr>
<tr>
<td>Alternative Coverage Options</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for Solae, MECS and Puerto Rico</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contact your carrier for plan design and coverage details.

See the “Highlights—Pre-Medicare Options” 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 and can provide you with a list of in-network providers (or you can search their provider directories online).

- You must satisfy the applicable annual deductible before coverage begins for most services. The deductible does not apply to covered preventive medical care, and prescription drugs on the Preventive Medications list. See “Preventive Medications” on page 32 for more information.

- Once the annual deductible is satisfied, the Plan pays a share of covered expenses (the coinsurance) and you pay the remaining share. A separate deductible applies to in-network and out-of-network claims.

- An annual out-of-pocket amount helps protect you against catastrophic costs for care received in-network. There is no out-of-pocket maximum for out-of-network care. See “Out-of-Pocket Maximums” on page 20 for more information.

- See “What Is Covered” on page 22 for further information about your benefits including information on emergency care, covered services and limitations and exclusions.
Save Money 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.

- You may contribute your own funds to the HSA.
- 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 though your employment with the Company has ended.

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 your first contribution, your account will be closed, and all funding will be returned to you. 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.

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

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

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

Refer to the Contacts section on page 68 for a list of carriers and their contact information. Or, contact your carrier using the information printed on your medical and pharmacy ID cards.

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

Allowable Charge Amounts
The Retiree Medical 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.

What Is a Health Savings Account?
The HSA is a special bank account available only to participants in 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 you. 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!

Medical ID Cards
Your Medical ID cards will be mailed to your home address from your medical carrier. You will receive a new ID card when changes to your personal information, carrier or Plan option occur.

Remember to take your ID card with you whenever and wherever you go for health care services. It identifies you as a Plan participant. If you need an additional set of ID cards, contact your medical carrier.
**Network Negotiated Rates**

The coverage networks include physicians, hospitals, pharmacies, labs and other providers that have agreed to accept negotiated fees for their services. Each health care provider and facility in the 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.

**Reasonable and Customary (R&C) Amounts (Out-of-Network)**

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

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

The determination on what are Reasonable and Customary charges is made by the Claims Administrator as an agent for the Plan Administrator, based on:

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

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

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

- If your doctor’s charges for covered services are less than or equal to the reasonable and customary charges, benefits apply to the full billed charges.
- If your doctor charges more than what is considered reasonable and customary, you pay your share of the covered R&C amount plus any excess fees.

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

**PRE-EXISTING CONDITIONS**

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

**DEDUCTIBLE**

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

<table>
<thead>
<tr>
<th>Medical Care Benefits</th>
<th>Core Option</th>
<th>Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(combined for medical</td>
<td>$1,400 for</td>
<td>$2,500 for you only</td>
</tr>
<tr>
<td>and prescription drug</td>
<td>you only coverage</td>
<td>you only coverage</td>
</tr>
<tr>
<td>claims)</td>
<td>$2,800 for</td>
<td>$4,000 for other</td>
</tr>
<tr>
<td></td>
<td>other coverage levels</td>
<td>coverage levels</td>
</tr>
<tr>
<td></td>
<td>$2,800 for you only</td>
<td>$3,500 for you only coverage</td>
</tr>
<tr>
<td></td>
<td>coverage levels</td>
<td>coverage levels</td>
</tr>
</tbody>
</table>

The annual deductible applies to most covered services, such as: office visits, prescription medications, mental health and chemical dependency care, and emergency care. The deductible is waived for covered preventive care (as described under “Preventive Care” on page 23) and prescription medications on the Preventive Medication list available from your prescription drug carrier.

The “you only coverage” deductible applies only if you have single coverage.

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

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

When you retire, your year-to-date deductible amount accumulated while you were an active employee participating in the Retiree Medical Plan will be applied towards your retiree 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.
<table>
<thead>
<tr>
<th>Medical Care Benefits</th>
<th>Core Option</th>
<th>Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td><strong>Coinsurance for medical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Office visits</td>
<td>You pay 20% after deductible</td>
<td>You pay 40% after deductible</td>
</tr>
<tr>
<td>▪ Mental health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Chiropractic care ($1,000 annual limit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Labs and X-Rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Core Option</th>
<th>Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>No charge after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Brand Formulary (“Preferred”)</strong></td>
<td>You pay 25% after deductible; $125 maximum per fill</td>
<td>You pay 25% after deductible; $125 maximum per fill</td>
</tr>
<tr>
<td><strong>Brand Non-Formulary (“Non-Preferred”)</strong></td>
<td>You pay 45% after deductible; $250 maximum per fill</td>
<td>You pay 45% after deductible; $250 maximum per fill</td>
</tr>
<tr>
<td><strong>Maintenance medications after second fill at retail pharmacies</strong></td>
<td>You pay 45% after deductible; no maximum</td>
<td>You pay 45% after deductible; no maximum</td>
</tr>
</tbody>
</table>

See “Prescription Drugs” on page 30 for additional information on prescription drug benefits.

### OUT-OF-POCKET MAXIMUMS

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

<table>
<thead>
<tr>
<th>Medical Care Benefits</th>
<th>Core Option</th>
<th>Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out of Pocket Maximum</strong> (annual amount, combined for medical and prescription drug claims)</td>
<td>In Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Each Person</td>
<td>$5,000</td>
<td>No limit</td>
</tr>
<tr>
<td>All Covered Family Members Combined</td>
<td>$10,000</td>
<td>No limit</td>
</tr>
</tbody>
</table>

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 Option), the Plan will pay 100% for all covered family members’ in-network care for the rest of the year.

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

When you retire, your year-to-date out-of-pocket amount accumulated while you were an active employee participating in the Retiree Medical Plan will be applied towards your retiree out-of-pocket maximum.

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

- All out-of-network expenses, including deductible and coinsurance amounts.
- Plan premiums.
• Charges above Reasonable and Customary or network-negotiated amounts, when applicable.
• Expenses for services that are not medically necessary or are not covered by the Plan.
• Expenses for infertility services and in-vitro fertilization procedures.
• Charges that exceed individual benefit maximums (e.g. chiropractic care expenses for which a $1,000 annual benefit maximum applies).
• Your coinsurance for prescription maintenance medications filled more than two times using a retail pharmacy in a 180-day period.

ANNUAL AND LIFETIME MAXIMUM BENEFITS

Annual Benefits
The Plan pays unlimited benefits for most covered medical services incurred for any one person during any plan year. The exceptions are:
• Chiropractic care. The maximum benefit for covered chiropractic care is $1,000 per person per year.
• Benefits for which an age or frequency limit may apply (such as certain preventive care services and exams). Contact your carrier using the number on your ID 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, infertility services and in-vitro fertilization procedures shall not exceed a lifetime family maximum of $15,000 for infertility medical treatments and $10,000 for infertility prescription drugs.
Expenses incurred under the lifetime infertility benefits are cumulative.
• If you use these services and later use them again, the earlier charges will continue to apply toward the lifetime maximum.
• If you change to a different Retiree Medical Plan option or a different carrier, earlier charges under the prior option or carrier will continue to apply toward the lifetime maximum.

Medically Necessary and Appropriate
The Retiree Medical Plan covers only medically necessary services, procedures and supplies. Generally, to be medically necessary, the expense must be for health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The services must be:
• in accordance with generally accepted standards of medical practice;
• clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
• not primarily for the convenience of the patient, physician, or other health care provider and not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

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

PRECERTIFICATION
Precertification is required for the following services:
• infertility treatment and in-vitro fertilization (call your medical carrier for precertification); and
- Applied Behavioral Analysis (call ComPsych for precertification)

Precertification is recommended for the following services:

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

To have your care precertified, you or your treating physician should contact your medical carrier (or ComPsych for mental health/chemical dependency care) by phone at least 14 days before the service or admission is scheduled. The medical carrier's toll-free number is on your ID card. If you are admitted to the hospital on an emergency basis, call your medical carrier within 48 hours or on the first business day after your admission—or have someone else call for you.

To request an extension of your ongoing treatment for your inpatient hospitalization beyond the length of time that was initially approved; you or someone on your behalf should contact your medical carrier at least 48 hours before the end of the initially approved period. Your medical carrier will notify you with a decision within 24 hours after the precertification request is made.

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

*What Is Covered*

The following services are covered under the Plan, subject to the Retiree Medical Plan deductibles, coinsurance, etc. All care must be medically necessary. Certain rules and restrictions apply. See “What Is Not Covered” on page 34.
Help Getting the Best Care

Because charges vary from provider to provider, even for in-network care, the Company provides you with a free Castlight health services comparison tool.

Castlight can help you compare charges of local providers based on the service you need. Plus, Castlight includes quality data and customer ratings to help you select the best care at the best price.

Castlight is available online or as a mobile app. Go to www.mycastlight.com to use the Castlight Consumer Tool.

PREVENTIVE CARE

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

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

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

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

Preventive Screenings and Exams

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

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

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

Gender-specific preventive care benefits are based on your gender at the time the services are received, regardless of the gender you were assigned at birth, your gender identity, or your recorded gender.
Routine Vaccinations
The Plan covers a list of immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. They are considered routine preventive care for use with children, adolescents and adults and range from childhood immunizations to periodic tetanus shots for adults.

Preventive Care for Children
The Plan covers preventive care services for children following guidelines developed by the Health Resources and Services Administration with the American Academy of Pediatrics. This includes regular pediatrician visits, vision and hearing screening (performed in a pediatrician/PCP’s office), developmental assessments, immunizations and screening and counseling to address obesity.

**Child Preventive Care Varies by Age and Gender**
Covered tests, immunizations and exams vary by age and gender. Covered services and age-based frequencies are subject to change, based on national recommendations set forth by the Affordable Care Act. Contact your medical carrier for a list of covered preventive care services.

OTHER MEDICAL CARE (NON-PREVENTIVE)

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

Physician Services
Covered services include:

- physician care
  - office visits
  - telephonic or technology enabled virtual doctor visits using the Teladoc service available through your medical plan carrier
  - outpatient surgical services
  - inpatient surgical services
  - inpatient hospital visits
  - inpatient hospital consultant services
  - home/nursing home visits
  - second surgical opinions (See “Second Surgical Opinions” on page 28 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 $1000 per person per plan year.

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/Corteva. At $40 per visit, a Teladoc doctor is significantly less expensive than urgent care and emergency room visits.
Using a Walk-In Clinic

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

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

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

Pregnancy and Maternity Care

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

- covered female employees;
- covered dependent spouses; and
- covered female dependents of a covered employee enrolled in the Retiree 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 Corteva Connection to add your newborn to coverage within 31 days of birth to receive benefits retroactive to the date of birth.

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

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

The Plan covers in-network and out-of-network emergency care provided in a hospital emergency room, urgent-care center or physician’s office. Ambulance expenses incurred for taking you to the nearest health care facility in an emergency are also covered. Benefits for true emergency services are covered at in-network levels (subject to R&C). Benefits for non-emergency services are applied at the in-network or out-of-network level based on the network status of the provider (the physician, hospital, urgent care center, ambulance company, etc.).

**Urgent Care**

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

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

**Emergency Care**

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

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

Examples of emergencies are:

- Loss of consciousness
- Poisoning
- Stroke
- Uncontrolled bleeding
- Acute asthma attack
- Convulsions
- Heart attack

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

Covered services include:

- Emergency care
  - In a doctor’s office
  - In a hospital emergency room or urgent-care center
professional ambulance service to the nearest health care facility capable of providing needed care

If you are traveling, working or living outside of the United States, you will pay the bill and then file a claim with your medical carrier. Be sure to get written details of your treatment to submit with your claim. In-network benefits apply to emergency care received outside the United States.

**Outpatient Surgery and Treatment**

Covered services include:

- outpatient surgical services
- outpatient hospital services
- home health care and outpatient private-duty nursing
  - Limited to medically necessary skilled-care services of an RN/LPN, excluding any custodial services and services by a nurse who is a member of the family of the patient or resides in the patient's home, as approved in advance by your medical carrier.
- outpatient short-term rehabilitation (physical, occupational and speech therapy)
  - Limited to “restorative” therapy, except for certain developmental coverage for children or physical therapy for some neurological diseases such as Multiple Sclerosis, Cerebral Palsy, Polio, Spina Bifida, Amyotrophic Lateral Sclerosis, Muscular Dystrophy or Parkinson’s Disease; call your medical carrier for details. The therapy must be expected to result in significant improvement in body function lost or impaired by the disease or be slowing further deterioration of body function for the neurological diseases cited above. Charges for services specifically to maintain a level of well-being are not covered.

**Hospitalizations and Other Inpatient Services**

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

- hospital services
  - inpatient room and board—coverage is for a semi-private room. If you stay in a private room, you pay the difference between its cost and the average cost of a semi-private room in that hospital.
  - inpatient operating and recovery room
  - inpatient ancillaries (supplies, tests, medications, therapies, etc.)
- Christian Science facility (in-network coverage may not be available in all areas)
  - Care must qualify as medically necessary, using the same standards applicable to other hospital care.
- extended-care facility
  - Limited to medically necessary skilled-care needs related to a recent hospital confinement as approved in advance by your medical carrier.
- inpatient short-term rehabilitation (physical, occupational and speech therapy)
  - Limited to “restorative” therapy, except for certain developmental coverage for children or physical therapy for some neurological diseases such as Multiple Sclerosis, Cerebral Palsy, Polio, Spina Bifida, Amyotrophic Lateral Sclerosis, Muscular Dystrophy or Parkinson’s Disease; call your medical carrier for details. The therapy must be expected to result in significant improvement in body function lost or impaired by the disease or be slowing further deterioration of body function for the neurological diseases cited above. Charges for services specifically to maintain a level of well-being are not covered.
Lab Work, X-Rays and Supplies
Covered services include:

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

Second Surgical Opinions
If you would like to receive a second opinion on a surgical procedure, a second-opinion office visit is covered by the Plan. The second surgical opinion must be made by a surgeon capable of performing the surgery who is not associated with or in partnership with the first surgeon. If the first and second opinions conflict, the Plan will cover a third opinion. Remember to take any tests or images with you since duplicate tests, x-rays and other images may be denied.

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

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

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

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

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

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

Transplant Services and Centers of Excellence
Coverage for human organ transplants.

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

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

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

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

Hospice Care
The Plan covers hospice care for terminally ill patients in the final stage of an incurable illness. Services must be in an approved, licensed hospice facility or program. Call your medical carrier to precertify hospice care. See “Precertification” on page 21 for more information.

Covered services include:

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

Examples of items not covered by the Plan include:

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

Dental Services
Covered services include:

- Emergency dental treatment related to the repair of sound natural teeth or other body tissues required because of an accidental injury.
- Treatment for temporomandibular joint (TMJ) and associated muscles for chewing, subject to review for medical necessity including, but not limited to: splints, physical therapy, trigger point injections and surgery. (Charges for the diagnosis of TMJ are covered by the Retiree Dental Plan.)

Non-Medical Dental Coverage
For information on the dental coverage available through the Retiree Dental Plan, see "Retiree Dental Plan" on page 41.
**PRESCRIPTION DRUGS**

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

Covered prescription drugs must meet the following criteria:

- drugs must be medically necessary as determined by the Retiree Medical Plan;
- prescribed by a licensed physician or nurse practitioner;
- not 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 available to retirees from Solae, MECS and residents of Puerto Rico, you must contact your medical carrier for prescription benefit information specific to your option.*

**How Prescription Coverage Works**

CVS Caremark is the Claims Administrator/carry for the Retiree Medical Plan’s prescription drug benefit for the Core and Premium Saver Options. The following section references CVS Caremark and their specialty medication subsidiary, Accredo. If you participate in an Alternative Coverage Option (for Solae, MECS and residents of Puerto Rico), contact your medical carrier for prescription coverage information. In the event that the Retiree Medical Plan changes prescription drug carriers, you will be notified and this summary will be updated.

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 Reasonable and Customary limits will apply.

Most prescription drug expenses are subject to the Retiree Medical 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.

Other important information about your prescription drug coverage:

- You can receive up to a 30-day supply of most prescription medications at a retail pharmacy or a 90-day supply using the mail order service. For some medications, a shorter day supply may apply. Examples include opioids (which may be limited to a 7-day supply) and drugs with a high initial patient rejection rate (which may be dispensed in an initial 7-day trial supply).
If a generic equivalent is available and you choose a Preferred Brand or Non-Preferred Brand drug, you will pay the difference in cost between the generic and brand price. The cost difference will not be applied to your deductible or out-of-pocket maximum.

When using a retail pharmacy for maintenance medications, a 45% coinsurance will apply to the third and subsequent fill and no maximum will apply to your share of the cost. While in the deductible phase and filling a maintenance medication three or more times at retail 55% of your cost will be applied to your deductible and out of pocket accumulators. The remaining 45% is considered coinsurance applied due to your third or more fill at retail and will not apply to your deductible or out of pocket accumulators. Even if you’ve reached your deductible and out-of-pocket maximum, the 45% coinsurance will still apply. To save money, switch to mail order through CVS Caremark.

Specialty medication will only be covered when purchased through the Plan’s specialty medication provider. See “Specialty Medications” on page 32 for additional information.

When taking a newly prescribed medication, it’s best to fill your first prescription at a network retail pharmacy for up to a 30-day supply. This allows you time to ensure that you don’t have an adverse reaction to the medication before starting home delivery. Subsequent prescriptions can be filled for up to a 90-day supply through the mail service program.

**Mail Order Service Home Delivery Program**

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

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

1. Mail your original prescription(s) with the CVS Caremark Pharmacy order form and required coinsurance. You can receive mail order forms by calling 1-800-793-8766, or through www.express-scripts.com/ Cortevaactive.

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 Corteva prescription plan ID card)

3. Ask your doctor to call 1-844-212-8696 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.

### What You Pay for Prescription Drugs

<table>
<thead>
<tr>
<th>Type of Medication</th>
<th>Amount You Pay For up to a 30-day supply at retail or a 90-day supply at mail order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Medications designated by the Affordable Care Act, including:</td>
<td>Free</td>
</tr>
<tr>
<td>▪ Generic Contraceptives</td>
<td></td>
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<tr>
<td>▪ Smoking cessation medications</td>
<td></td>
</tr>
<tr>
<td>▪ Colonoscopy bowel preps</td>
<td></td>
</tr>
<tr>
<td>Preventive Medication List</td>
<td>No deductible applies. Co-insurance may apply depending upon type of drug dispensed.</td>
</tr>
<tr>
<td>Generic</td>
<td>Free after meeting the deductible</td>
</tr>
<tr>
<td>Brand Formulary (Preferred)</td>
<td>25% coinsurance after deductible; $125 maximum</td>
</tr>
<tr>
<td>Brand Non-Formulary (Non-Preferred)</td>
<td>45% coinsurance after deductible; $250 maximum</td>
</tr>
<tr>
<td>Maintenance medications filled more than two times at retail pharmacies</td>
<td>45% coinsurance after deductible; no maximum</td>
</tr>
</tbody>
</table>
Generic Drugs
Generic medications are covered at 100% after meeting your deductible when purchased through CVS Caremark or a participating pharmacy. 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 and Premium Saver Options provide benefits for covered preventive medications that are not subject to the Plan’s deductible. To see if your medication is classified as preventive, go to the CVS Caremark website at www.express-scripts.com/Cortevaactive. Click “GO” under the Open Enrollment Information tab and choose your medical plan type. The most up-to-date preventive medications list is available here to confirm your medication’s classification. It is recommended you always reference the website for current information as the list will change over time.

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

Specialty Medications
Specialty medications are drugs that are used to treat complex conditions, such as anemia, growth hormone deficiency, hemophilia, hepatitis C, high cholesterol, multiple sclerosis and rheumatoid arthritis. CVS Caremark manages specialty medications through Accredo. To confirm whether your medications are considered specialty medications, contact CVS Specialty at 1-800-237-2767.

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

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

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

- Prior Authorization—Requires you to obtain approval through a coverage review. A coverage review is performed to determine whether the use of the medication qualifies for coverage.

How Financial Assistance Impacts Cost-Sharing
When you receive financial assistance (such as a manufacturer’s coupon for prescription drugs), the amount of financial assistance may be applied towards the total allowed cost.

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

\textbf{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.

\textbf{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.

\textbf{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.

\textbf{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.

\textit{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.

\textbf{MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE (MH/CD)}

ComPsych is the Claims Administrator/carer for Retiree Medical Plan’s MH/CD benefit for the Core and Premium Saver Options. The following section references ComPsych. If you participate in an Alternative Option (for Solae, MECS and residents of Puerto Rico), contact your medical carrier for MH/CD coverage information. In the event that the Retiree Medical Plan changes MH/CD carriers, you will be notified and this summary will be updated.

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

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

Like all other non-preventive care services covered by the Plan, expenses for the treatment of mental health and chemical dependency are subject to the deductible. Once the deductible is satisfied, the Plan provides 80% in-network benefits until you reach the out-of-pocket maximum and begin receiving 100% benefits in-network. For out-of-network care, the Plan provides 60% benefits after the deductible with no out-of-pocket maximum.

Covered services include:

- inpatient (when medically necessary) care at a hospital or specialized treatment center approved by ComPsych

\textbf{Be Sure to Use a Provider in the ComPsych Network}

Because mental health and chemical dependency (MH/CD) care benefits are administered by ComPsych, you will generally receive the highest benefit when you use a ComPsych network provider. If you use a Highmark BCBS or Aetna MH/CD provider who is not in the ComPsych network, the benefit will be paid at the out-of-network rate.
• office visits and outpatient mental health care and chemical dependency care
• Applied Behavioral Analysis (ABA) therapy for the treatment of autism spectrum disorder. Call ComPsych at 1-800-435-7266 to review medical necessity and identify network providers. All ABA treatment must be pre-approved by ComPsych.

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

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

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

To schedule an EAP session, call ComPsych at 1-833-787-7771. If additional or more intensive mental health or chemical dependency care is required, the Plan benefits apply.

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

• charges covered by any other plan of the Company
• charges covered under any national or local law (except charges relating to a government group insurance plan for that government’s own civilian employees)
• charges due to an occupational illness or injury
• charges for any services performed by a resident physician or intern of a hospital when billed directly—their services are included in the hospital’s bill
• charges for care rendered to any dependent once they cease to be eligible
• charges for chiropractic care other than X-rays, manipulations of the spine, heat and ultrasound treatment, therapeutic procedures and activities, traction and electrical stimulation
• charges for communication equipment such as augmentative speech devices
• charges for cosmetic surgery, unless it is necessary for prompt repair of a non-occupational injury or is related to a visible congenital defect of an eligible newborn child
• charges for custodial care, regardless of who recommends or provides the care
• charges for eyeglasses, contact lenses and hearing aids (or examinations for the prescription or fitting of them), except for one pair of eyeglasses or contact lenses after cataract surgery
• charges for hospitalization primarily for diagnostic studies, X-ray or laboratory examinations, electrocardiograms, electroencephalograms or physical therapy except, when medically necessary
• charges for immunizations required for personal international travel
• charges for in-hospital physician visits for any day the physician does not visit the covered patient
• charges for inpatient or outpatient hospitalization for dental care, unless confinement is due to accidental bodily injury, or when a physician other than a dentist certifies that the hospital setting is necessary to safeguard the life or health of a patient
• charges for items available for purchase over the counter, regardless of who recommends the purchase.
▪ prescription medication available in the same or lower dosage over the counter, unless it is considered preventive care by the Affordable Care Act.
▪ charges for missed appointments or copying medical records
▪ charges for nonmedical equipment or items intended for the comfort/convenience of the patient, such as exercise cycles, hot tubs, stairway elevators, humidifiers
▪ charges for orthopedic appliances (including orthotics) when they are primarily used as supportive devices for the feet
▪ charges for personal services such as phone, TV, guest meals
▪ charges for routine physical examinations outside the scope of the Basic Preventive Services Schedule
▪ charges for services and associated expenses considered experimental or investigative
▪ charges for services not widely accepted by the U.S. medical community as safe and effective treatment for illness or injury (for example, most applications of acupuncture or non-abstinence-based treatment for chemical dependency)
▪ charges for services or supplies not medically necessary or appropriate for the diagnosis and treatment of the illness or injury, except for preventive procedures described herein
▪ charges for services or supplies not recommended by a licensed physician or practitioner
▪ charges for services or supplies not specifically defined as covered expenses
▪ charges for services or supplies specifically to maintain a level of well-being
▪ charges for services provided by an unlicensed physician or practitioner
▪ charges for TMJ diagnosis and for TMJ treatment involving the teeth, such as crowns, inlays/onlays, bridges, full and partial dentures, or orthodontics
▪ charges for travel other than what may be authorized under “Centers of Excellence” Transplant Program
▪ charges for treatment to a person after that person is no longer eligible for coverage under this Plan
▪ charges for treatment to a person before that person becomes eligible for coverage under this Plan
▪ charges in excess of carrier-negotiated fees or Reasonable and Customary charges
▪ charges incurred for any medical observation or diagnostic study when no disease or injury is revealed, unless: the covered person had definite symptoms of illness or injury other than hypochondria; or the observation or studies were not part of a routine physical examination; or the request for benefit is in order in all other respects
▪ charges not reported, benefits not claimed, or payments not cashed for more than two years
▪ charges related to an act of war, declared or undeclared, if the injury or illness occurs after the person is covered under this Plan
▪ charges related to dental treatment except charges for repair of natural teeth or other body tissues required because of accidental injury
▪ charges relating to past or present military service
▪ charges resulting from any occupation or work outside the Company for compensation or profit
▪ charges that are associated with injuries suffered due to the act or omission of a third party
▪ charges that would not have been made had the patient not been covered under this Plan, or charges that the participant or his or her eligible dependents are not legally obligated to pay
▪ second or third opinions concerning procedures not covered by this Plan or required by a hospital
▪ charges for the cost difference between a brand-name medication and its generic equivalent
▪ charges for prescription vitamin and mineral products, unless the prescription is considered preventive care by the Affordable Care Act.
Using a Health Savings Account (HSA)

The HSA is not part of the Corteva Retiree Medical Plan. It is an account that you can open through an HSA trustee, such as a bank or other financial institution. The information provided here is for general educational purposes only.

If you are enrolled in either the Core or Premium Saver Retiree Medical Plan options as a retiree, you can participate in a Health Savings Account (HSA) if you choose. The HSA is available to you 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 use the money in the HSA to pay for future out-of-pocket health care expenses for you and your tax dependents.

To open an optional, tax-free personal Health Savings Account (HSA), contact Bank of America (the Corteva HSA administrator) or another financial institution of your choice. For more information about HSA eligibility, see IRS Publication 969 at www.irs.gov/publications/p969.

WHO IS ELIGIBLE?

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

▪ You cannot be covered by another medical plan that is not a qualifying high-deductible plan, either as an individual or as a participant. (Your covered dependents may have other medical coverage.)

▪ You cannot be enrolled in Medicare.

▪ You cannot be covered by a full-purpose Health Care Spending Account (also known as a Flexible Spending Account, or FSA) or Health Reimbursement Account (for example, through a previous employer or spouse’s FSA or HRA) that pays or reimburses medical expenses during the same time period.

▪ Another individual cannot claim you as a tax dependent.

HSA PLAN LIMITS

For 2019, the HSA contribution limits will be as follows:

▪ single – $3,500

▪ family – $7,000

▪ 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 provided by Corteva while you were an active employee. 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

▪ acupuncture

▪ chiropractic services

▪ hearing aids (including batteries)

Triple Tax Savings

With an HSA, you benefit from a triple tax savings:

▪ You pay no federal taxes on your money when it goes in

▪ No federal taxes as it grows and

▪ No federal taxes when you use it to pay eligible expenses.
- long-term care medical expenses and insurance premiums
- tobacco cessation programs
- physical therapy
- psychiatric care
- psychological counseling
- nursing home care

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

Help Prevent Fraud, Waste and Abuse

Fraud increases the cost of health care for everyone and increases your Retiree 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.
- Do not share medications or supplies with other individuals.
- 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).
After You Become Eligible for Medicare

Your Corteva medical coverage ends the first of the month in which you or a covered dependent becomes eligible for Medicare.

You are generally eligible for Medicare when:

- You turn age 65, or
- You become Medicare-eligible before age 65 due to a disability other than End-Stage Renal Disease.

Retirees from Corteva*, Pioneer*, Genencor and MECS receive a Health Reimbursement Arrangement (HRA) account from the Company to purchase medical coverage as a supplement to Medicare. Solae retirees do not receive the HRA, as their coverage ends.

There are important actions that you must take within 60 days of becoming eligible for Medicare in order to receive your HRA. See “How to Enroll” starting on page 7 for details.

Highlights

The Company provides eligible retirees, Survivors and covered dependents with a Health Reimbursement Arrangement (HRA) account if you purchase a health plan through Via Benefits. If you participated in the Plan’s medical coverage prior to becoming eligible for Medicare, you will need to purchase either a Medicare Supplement or Medicare Advantage individual insurance plan from Via Benefits in order to receive the HRA. Purchase of a dental plan or prescription drug plan is optional.

- The amount of HRA funding varies by Company. Proration of the HRA annual amount may apply if you are an early retiree. More information on proration of the Company’s Retiree Medical Plan contribution can be found under “How Corteva Funds the HRA” on page 40.

The HRA can be used to reimburse the cost of health insurance plans and qualifying out of pocket health care costs for you and your covered dependents. Examples of qualifying costs include: monthly premiums for your health insurance plans purchased through Via Benefits, deductibles, copayments, prescription expenses, dental and vision expenses. The HRA cannot be used towards Long Term Care (LTC) premiums.

- Retirees and Survivors must continue coverage for themselves through Via Benefits in order for their dependents to be eligible for either the HRA or Corteva pre-Medicare coverage.

- If you cancel the medical insurance you purchased through Via Benefits, your HRA account will also end on the date your cancelled coverage ends. Once cancelled, you forfeit any remaining HRA account funds. Cancellation is permanent and irrevocable.

Contact Via Benefits ASAP

As soon as you become eligible for Medicare, contact Via Benefits at 1-855-535-7140 to ensure you enroll for coverage within 60 days, so you receive the Company-provided Health Reimbursement Arrangement, if eligible.
How Corteva Funds the HRA

If you are eligible for the HRA, Corteva makes an annual contribution for you and your covered, Medicare-eligible dependents into your HRA account. You can use the HRA funds in your account towards the cost of the coverage purchased through Via Benefits and other qualifying expenses for you and your Medicare covered dependents.

The Corteva annual contribution for each participating Company is:

<table>
<thead>
<tr>
<th>Annual HRA Amount per person</th>
<th>Corteva</th>
<th>Corteva Puerto Rico (DACI, DEMI)</th>
<th>Pioneer</th>
<th>Genencor</th>
<th>MECS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$1,200</td>
<td>$1,200 medical</td>
<td>$1,200</td>
<td>$1,200 medical</td>
<td>$1,400 medical</td>
</tr>
<tr>
<td>Prorated for early retirement?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes, if less than 25 years of service at retirement</td>
</tr>
</tbody>
</table>

Your HRA Company contribution may differ from those shown above based on various factors such as your Company, age and service at retirement. Call Corteva Connection if you have questions about your proration factor.

Retirees who cover eligible dependents will have a joint HRA with their covered dependents. For example, if you cover yourself and your spouse and both of you are eligible for Medicare and have qualified for the HRA, the Company will put the HRA funding for both you and your spouse into one HRA account that you and your spouse can share.

The Company’s annual HRA contribution will not increase in the future.

If You Live Outside of the U.S.

If you are living in Puerto Rico or outside of the U.S. when you reach age 65, you also receive an HRA from Corteva. You may use your HRA to reimburse your qualifying expenses or premiums for an individual medical or dental plan you purchase. Since Via Benefits does not sell insurance plans in Puerto Rico or outside of the U.S., the requirement to buy a medical or dental plan through Via Benefits is waived while you live outside the Via Benefits sales footprint.
Retiree Dental Plan

The Retiree Dental Plan (the “Dental Plan”) encourages good preventive care to help you maintain healthy teeth and gums. The Program provides Pre-Medicare coverage under a choice of two dental options. Medicare-eligible participants may qualify to receive a Health Reimbursement Arrangement (HRA) contribution from the Company to help supplement out-of-pocket dental expenses.

Questions?

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

SECTION CONTENTS

Highlights – Pre-Medicare Dental Plan Options ................................................................. 42
Your Pre-Medicare Dental Plan Options ........................................................................ 42
The MetLife Preferred Dental Program (PDP) Plus Network ........................................ 43
Cost of Coverage ............................................................................................................. 43
How Coverage Works ........................................................................................................ 44
Reasonable and Customary (R&C) Amounts .................................................................. 45
Allowable Charge Amounts ............................................................................................... 45
Pre-existing Conditions ..................................................................................................... 45
Deductibles .......................................................................................................................... 45
Coinsurance ......................................................................................................................... 45
Annual Benefit Maximum ................................................................................................ 46
Lifetime Orthodontia Maximum Benefits ......................................................................... 46
Predetermination of Benefits ............................................................................................. 46
What Is Covered .................................................................................................................. 47
Preventive and Diagnostic Care (Limited Option and Standard Option) ...................... 47
Restorative and Other Care (Standard Option only) ....................................................... 47
Orthodontia (Standard Option only) ................................................................................ 48
What Is Not Covered ........................................................................................................... 49
After You Become Eligible for Medicare ....................................................................... 50
Highlights ............................................................................................................................ 50
Highlights—Pre-Medicare Dental Plan Options

The Dental Plan includes two dental options available to retirees, Survivors and their dependents of Corteva and Pioneer (including Puerto Rico subsidiaries). Dental Plan coverage is not offered to retirees or Survivors of other Companies.

An outline of the two Dental Plan options is shown below. Read the full summary for more details.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard Option Benefits</th>
<th>Limited Option Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible for Restorative Care</td>
<td>$50 per person, up to a maximum of $150 per family</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Preventive and Diagnostic Care</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>▪ 2 regular or 4 periodontal cleanings per year (with diagnosed condition)</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>▪ 1 set of Bitewing X-Rays per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ 1 set of whole mouth X-rays every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative and Other Dental Care</td>
<td>50%*</td>
<td>None</td>
</tr>
<tr>
<td>▪ Bridges, crowns, fillings and other covered dental services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,100 per person</td>
<td>$500 per person</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum Benefit</td>
<td>100%, up to $1,200 per child under age 19</td>
<td>None</td>
</tr>
</tbody>
</table>

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

Your Plan Is Part of the MetLife PDP Plus Network

The Dental Plan is administered by MetLife. When you use benefits providers in the MetLife Preferred Dentist Program Plus (PDP Plus) network, you receive MetLife’s negotiated pricing, which may save you money!

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

Your Pre-Medicare Dental Plan Options

If you are an eligible retiree or Survivor, you may participate in the Dental Plan until you become eligible for Medicare or turn age 65 (whichever occurs first).

The Retiree Dental Plan has two options:

▪ The Limited Option is provided at no cost to you—the Company pays the full cost. (The Company contribution is prorated for some retirees. See “Cost of Coverage” on page 43 for information on proration factors.)

▪ The Standard Option provides more generous benefits, but you pay the additional cost, over the cost of the Limited Option.

You can also waive coverage. Waiving coverage is a permanent and irrevocable option (unless you can show proof of losing continuous coverage under another employer’s group health plan or governmental health plan). See “When You Drop Coverage” on page 21 for details.

See “After You Become Eligible for Medicare” on page 50 for more details about coverage available to Medicare-eligible retirees, Survivors and dependents.
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 Corteva, 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 Corteva. Also, PDP Plus participating dentists agree not to balance bill you any amount over the negotiated fee.

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

Cost of Coverage

The Company pays the full cost of the Limited Option, not only for your coverage but also for any eligible dependents that you enroll. (The Company contribution is prorated for certain retirees.)

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

Here are the monthly retiree premiums for 2019, which depend on your coverage level:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Limited Option</th>
<th>Standard Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>You only</td>
<td>$0</td>
<td>$17</td>
</tr>
<tr>
<td>You plus spouse</td>
<td>$0</td>
<td>$32</td>
</tr>
<tr>
<td>You plus child(ren)</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>You plus family</td>
<td>$0</td>
<td>$54</td>
</tr>
</tbody>
</table>

Your premiums may differ from those shown based on various factors such as your age and service at retirement. You will be provided with a personalized statement of premiums on an annual basis.

The premiums listed are effective for the 2019 plan year. Your premiums are reviewed annually and are subject to change. You will be notified in advance of any premium changes. See your personal benefit enrollment materials (which you receive before Annual Enrollment) for your current pricing information.

**Prorated Premiums—For Corteva participants only**

*Early retirees who terminated employment on or after January 1, 1994 pay a higher monthly premium than those shown in the table above. The Company contribution for dental coverage is prorated based on your age and service at the time of retirement (when your employment with the Company ends). Example: If you retired early and had a 50% reduction factor at the time you terminated employment, you would pay the premium shown in the table plus 50% of the standard Company share of the premium. This factor will also be applied to any Survivor’s dental premium and any HRA funds that you or your*
dependents receive after becoming eligible for Medicare. Contact Corteva Connection to verify your reduction factor.

How Coverage Works

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

- **The Limited Option:**
  - Covers 100% of the allowable charge for preventive and diagnostic care.
  - Benefits are limited to a maximum of $500 per person per year.
  - Restorative and other care, including orthodontic care is not covered.

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

Coverage and 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.

**Alternative Treatment**

The Dental 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

---

**Amounts Before Retirement Begins Are Included**

When you retire, your year-to-date amounts accumulated while you were an active employee participating in the Dental Plan will be applied towards your retiree amounts, for the deductible, and plan maximums.
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.

Reasonable and Customary (R&C) Amounts
Reasonable and customary (R&C) amounts are typical fees for services, treatments or supplies charged by most providers with similar training and experience in the same geographic area.

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

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

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

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

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

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

Deductibles
An annual deductible of $50 per person, up to a maximum of $150 per family, applies to restorative and other dental care (including bridges, crowns, fillings, and other major care and emergency care) under the Standard Option. (No deductible applies to the preventive and diagnostic care or orthodontia care.) You must satisfy the annual deductible before the Plan provides coverage for restorative and other dental care services.

The Limited Option has no deductible.

Coinsurance
Coinsurance is the percentage you pay after you meet the deductible (if applicable). The Dental 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’s coinsurance is 50% of the allowable charge. The Plan pays a 50% benefit, subject to frequency and benefit limits.
- For Orthodontia, the Standard Plan pays 100% up to the lifetime orthodontia maximum of $1,200 per child under age 19. Coinsurance does not apply, but you are responsible for charges over the lifetime orthodontia maximum.
- There is no coverage for restorative and other dental care under the Limited Option.

**Annual Benefit Maximum**

The annual benefit maximum is the maximum dollar amount the Dental Plan will pay for dental services received during the plan year. The annual benefit maximum is:

- $500 per person under the Limited Option and
- $1,100 per person under the Standard Option.

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

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

See “If You Have Other Coverage” on page 53 and “What Is Not Covered” on page 49 for more information.

**Lifetime Orthodontia Maximum Benefits**

The maximum the Dental Plan pays for orthodontia care is a lifetime limit of $1,200 for the Standard Option. The Standard Option covers orthodontia services for dependent children under age 19.

Orthodontia is not covered under the Limited Option.

**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 (Limited Option and Standard Option)**

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—one every 36 months on primary or permanent posterior teeth for dependent children under age 19 only
- space maintainers for prematurely lost or extracted teeth, for dependent children under age 19 only
- tests and laboratory examinations, when necessary for dental diagnosis, prevention and treatment
- emergency palliative treatment of dental pain
  - subsequent follow-up care may be considered restorative
- X-rays
  - full-mouth X-rays, once per person every 60 months (5 years)
  - supplementary bitewing X-rays, once per person each plan year
  - any dental X-rays required to diagnose a specific condition needing treatment, as necessary

**Restorative and Other Care (Standard Option only)**

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

- bridges
  - initial installation of fixed bridgework, including inlays and crowns to form abutments, to replace one or more teeth (except wisdom teeth)
  - repair or recementing of bridgework
  - replacement of an existing bridge, provided that it is at least five years old and cannot be made serviceable
• crowns
  ▪ initial installation of a crown to restore the structure of a tooth due to cavity or fracture
  ▪ repair or recementing of crowns

• dentures
  ▪ initial installation of removable dentures, partial or full, including adjustments after the six-month period after installation, to replace one or more teeth (except wisdom teeth)
  ▪ addition of teeth to an existing partial removable denture at least six months after installation
  ▪ repair of dentures
  ▪ relining of dentures after six months from the date of installation
  ▪ replacement of a temporary denture with a permanent full denture within 12 months of when it was installed
  ▪ replacement of an existing denture, provided that it is at least five years old and cannot be made serviceable. The five-year replacement limitation does not apply if you have experienced documented, substantial changes to the dimensions of your oral cavity, or have lost or extracted teeth while covered by the Plan.

• periodontics—treatment for diseases of the structures surrounding and supporting the teeth, such as the gums

• endodontics—treatment for diseases of the dental pulp, such as root canal therapy

• inlays
  ▪ initial installation of an inlay to restore the structure of a tooth due to cavity or fracture
  ▪ repair or recementing of inlays

• implantology (placing teeth or supports in a surgically prepared cavity) where medically necessary

• oral surgery
  ▪ surgical procedures in and around the mouth, including extractions of badly decayed or impacted teeth
  ▪ general anesthesia, when medically necessary in connection with covered oral surgery and administered in a dentist’s office. When medical necessity dictates that oral surgery be done in a hospital (inpatient or outpatient), the anesthesia and facility charges may be covered by your medical plan.

• restorations—treatment to restore the structure of a tooth or teeth because of cavities or fracture. This includes fillings, inlays, onlays and crowns, along with the necessary local anesthesia.

**Orthodontia (Standard Option only)**

The Standard Option will cover orthodontic expenses incurred for corrective treatment of maloccluded or malpositioned teeth by means of an active appliance for dependent children under age 19. 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

---

**Standard Option Covers Orthodontia for Children Only**

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

Orthodontia is not covered under the Limited Option.
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.
- Orthodontia benefits apply to services received up to the day before the child’s 19th birthday.
- Benefits are paid quarterly at the end of the quarter.

**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
- charges which, in the judgment of the Claims Administrator, exceed the reasonable and customary charge for (or fair and reasonable value of) the service or supply provided
- completion of claim forms or filing of claims
- educational programs, such as training in plaque control or oral hygiene, or for dietary instructions
- experimental procedures or those not recognized by the dental profession
- extra sets of dentures or other appliances
- for job-related injuries or diseases paid by any Workers’ Compensation or similar laws (See the disability benefits summary, Disability Benefits, for more details)
- missed appointments
- periodontal splinting (temporary wiring or permanently bonding teeth together)
- replacement of lost or stolen prosthetic devices
- services or supplies not recommended by your dentist as necessary for proper dental treatment
- temporary procedures, services or appliances
- treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot or service in the armed forces of any government
- treatment of temporomandibular joint dysfunction (TMJ) (Note: An exam to diagnose TMJ is covered under the Dental 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

After You Become Eligible for Medicare
Your pre-Medicare Dental Plan coverage ends the first of the month in which you or a covered dependent becomes eligible for Medicare or turn age 65 (whichever occurs first).

You are generally eligible for Medicare when:
▪ You turn age 65, or
▪ You become Medicare-eligible before age 65 due to a disability other than End-Stage Renal Disease.

Retirees from Corteva and Pioneer (including Puerto Rico subsidiaries) receive a Health Reimbursement Arrangement (HRA) account from the Company to purchase coverage as a supplement to Medicare.

There are important actions that you must take within 60 days of becoming eligible for Medicare in order to receive your HRA. See the section titled ‘How to Enroll’ starting on page 7 for details.

Highlights
▪ The Company provides eligible retirees, Survivors and covered dependents with a Health Reimbursement Arrangement (HRA) account if you were covered on the Dental Plan immediately prior to becoming eligible for Medicare and purchase an individual medical plan through Via Benefits.
  - If you participated in the Plan’s dental coverage (but not medical coverage) prior to becoming eligible for Medicare, you must enroll in an individual dental insurance plan from Via Benefits in order to receive the HRA. Purchase of a medical or prescription drug plan is optional.
  - If you participated in the Plan’s medical coverage prior to becoming eligible for Medicare, you will need to purchase either a Medicare Supplement or Medicare Advantage individual insurance plan from Via Benefits in order to receive the HRA. Purchase of a dental plan or prescription drug plan is optional.
Example: Josephine is covered by both the Retiree Medical Plan and the Dental Plan when she becomes eligible for Medicare at age 65. She calls Via Benefits and purchases an individual Medicare Supplement plan. She chooses not to purchase an individual dental plan. She will still receive her Dental Plan annual HRA account funds and can use the funds to pay for her qualifying out-of-pocket medical and/or dental expenses.
▪ The amount of HRA funding varies by Company. Proration of the HRA annual amount may apply if you are an early retiree. More information on proration of the Company’s Dental Plan contribution can be found under “How Corteva Funds the HRA” on page 40.
▪ The HRA can be used to reimburse the cost of health insurance plans and qualifying out of pocket health care costs for you and your covered dependents. Examples of qualifying costs include: monthly premiums for your health insurance plans purchased through Via Benefits, deductibles, copayments, prescription expenses, dental and vision expenses.
▪ If you cancel the dental insurance you purchased through Via Benefits, your HRA account will also end on the date your cancelled coverage ends.
▪ Retirees and Survivors must continue coverage for themselves through Via Benefits in order for their dependents to be eligible for either the HRA or Corteva pre-Medicare coverage.
HOW CORTEVA FUNDS THE HRA

If you are eligible for the HRA, Corteva makes an annual contribution for you and your covered, Medicare-eligible dependents into your HRA account. You can use the HRA funds in your account towards the cost of the coverage purchased through Via Benefits and other qualifying expenses for you and/or your spouse.

The annual Company Dental Plan contribution is:

<table>
<thead>
<tr>
<th></th>
<th>Corteva</th>
<th>Corteva Puerto Rico (DACI, DEMI)</th>
<th>Pioneer (including Puerto Rico subsidiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual HRA Amount per person</td>
<td>$200 dental</td>
<td>$200 dental</td>
<td>$200 dental</td>
</tr>
<tr>
<td>Prorated for early retirement?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Your HRA Company contribution may differ from those shown above based on various factors such as your Company, age and service at retirement. Call Corteva Connection if you have questions about your proration factor.

If You Live Outside of the U.S.

If you are living in Puerto Rico or outside of the U.S. when you reach age 65, you also receive an HRA from Corteva. You may use your HRA to reimburse your qualifying expenses or premiums for an individual medical or dental plan you purchase. Since Via Benefits does not sell insurance plans in Puerto Rico or outside of the U.S., the requirement to buy a medical or dental plan through Via Benefits is waived while you live outside the Via Benefits sales footprint.
Claiming Benefits

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.

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.

How to File a Claim

<table>
<thead>
<tr>
<th>Type of Care/Claim</th>
<th>How to File</th>
</tr>
</thead>
</table>
| **Medical Care (Core and Premium Saver Options)**<br>From an in-network provider | ▪ You don't need to file claims if you use a network provider. Your network provider will file the claim for you.  
▪ Your provider may ask you to pay your share of the claim costs when you receive the care or they may bill you.  
▪ Don't forget that some care must be pre-certified. |
| **Medical Care (Core and Premium Saver Options)**<br>From an out-of-network provider | ▪ For out-of-network services, the best method is to bring a claim form with you when you need care. In some cases, your provider or facility may submit the claim form on your behalf. You can get claim forms from the carrier website.  
▪ Alternatively, you can file a claim after you've received the care. In this case, you would pay your provider for the cost of your care and then file a claim with the carrier for reimbursement. The claim form has instructions on what you will need to provide. |
| Prescription Drugs | ▪ When you use a pharmacy in the 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 they are 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 (detailed pharmacy receipt is required). |
| Mental Health/Chemical Dependency (MH/CD) Care<br>From an in-network provider | ▪ You are encouraged to contact ComPsych at 1-833-787-7771 before you need care, for assistance in finding a network provider.  
▪ If you visit a ComPsych network provider, they will file claims on your behalf. You may be asked to pay your share of the claim costs when you receive the care or they may bill you. ComPsych will notify you and the provider of the contracted rate and the amount you are responsible for paying the provider (if deductible/coinsurance has been satisfied). |
| Mental Health/Chemical Dependency (MH/CD) Care<br>From an out-of-network provider | ▪ If you receive care from an out-of-network provider, it is common for the providers to ask you to pay the full amount and file a claim for reimbursement with ComPsych yourself.  
▪ Claim forms can be obtained from ComPsych by calling 1-833-787-7771. The claim form has instructions on what you will need to provide. |

Need a New ID Card?

Have you lost your medical or CVS Caremark ID card, or do you need a new one for a covered family member? Contact the carrier for your plan, or visit their website. See Contacts on page 68.
### Type of Care/Claim

<table>
<thead>
<tr>
<th>Type of Care/Claim</th>
<th>How to File</th>
</tr>
</thead>
</table>
| Dental Care  
*From an in-network provider* | ▪ You don’t need to file claims if you use a MetLife PDP Plus network provider. The Plan will reimburse the provider for the share of the cost it pays.  
▪ Your provider may ask you to pay your share of the claim cost when you receive the care or they may bill you.  
▪ For more complex procedures, take advantage of the pre-treatment estimate so you are not surprised by the cost. |
| Dental Care  
*From an out-of-network provider* | ▪ For non-PDP Plus dentists, the best method is to bring a claim form with you when you need care. In some cases, your dentist may submit the claim form on your behalf. You can get claim forms from the MetLife website, at www.metlife.com/mybenefits.  
▪ Alternatively, you can file a claim after you’ve received care. In this case, you would pay your dentist for the cost of your care and then file a claim with the carrier for reimbursement. The claim form has instructions on what you will need to provide.  
▪ For more complex procedures, take advantage of the pre-treatment estimate so you are not surprised by the cost. |

### IF YOU HAVE OTHER COVERAGE

If you or a covered dependent is also enrolled in another group medical plan (in addition to the Company’s Retiree Medical 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 medical plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called “primary”; the other plan is called “secondary.”

- 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).

**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.

**For a Retiree/Survivor, Employee or Dependent**

- A plan that covers a participant as an employee or retiree/Survivor will be primary to a plan that covers the person as a dependent.
- A plan that covers a participant as an employee will be primary to a plan that covers the person as a retiree/Survivor.
- Medicare is primary to a plan that covers a participant as a retiree or a dependent of a retiree.
- 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.
Additional COB for 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 with court-order:
  - The plan of the parent whom the court said is responsible for health coverage is primary. But if that parent has no coverage then the other spouse's plan is primary.

- Parents separated, divorced, not living together or have a court-order that states both parents are responsible for coverage or have joint custody:
  - Primary and secondary coverage is based on the birthday rule. The plan of the parent whose birthday falls earlier in the calendar year is primary before the plan of the parent whose birthday falls later that year (based on month and day only). If both parents have the same birthday, the plan covering the person for the longest time is considered primary before the plan that covers the other person.

- Parents separated, divorced, or not living together and there is no court-order:
  - The order of benefit payments is:
    - The plan of the custodial parent pays first
    - The plan of the spouse of the custodial parent (if any) pays second
    - The plan of the noncustodial parent pays next
    - The plan of the spouse of the noncustodial parent (if any) pays last

Medicare-Eligible Due to ESRD
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 Retiree 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.

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 medical carrier with questions on how coordination of benefits works with your coverages.
Assignment of Benefits

When you file a claim, you can direct your 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.

Claims Review Notification and Explanations of Benefits

Timing for Notification of Claims

Your 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:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Medical and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service urgent care claims</td>
<td>As soon as possible, taking into account the health circumstances that require action. Your carrier will contact you within 72 hours.</td>
</tr>
<tr>
<td>Pre-service non-urgent claims</td>
<td>Within 15 days</td>
</tr>
<tr>
<td>Post-service claims</td>
<td>Within 30 days</td>
</tr>
</tbody>
</table>

For pre-service and post-service claims, your carrier may extend the decision-making timeframe for one additional period of 15 calendar days after the expiration of the initial notification period, if it is necessary for reasons beyond the control of the Plan. You will receive written notification indicating the circumstances requiring the extension and when the Claims Administrator expects to provide a determination. If your claim is a pre-service urgent-care claim, you will be notified orally with the circumstances requiring an extension and when your carrier expects to provide you a benefit determination.

IF ADDITIONAL INFORMATION IS REQUIRED

If you are required to submit additional information, the initial notification deadline for your claim determination is suspended from the time you are contacted for such additional information and until you return the requested information. This is called the tolling period. The tolling period ends on the date the Plan receives your response to the notice, without regard to whether or not you have supplied all the necessary information to decide the claim or on the date such information was due if you did not respond. You must respond with the missing information within the following timeframe:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Medical and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service urgent care claims</td>
<td>As soon as possible, but not later than 48 hours</td>
</tr>
<tr>
<td>Pre-service non-urgent claims</td>
<td>Within 45 days</td>
</tr>
<tr>
<td>Post service claims</td>
<td>Within 45 days</td>
</tr>
</tbody>
</table>
IF A CLAIM IS DENIED OR REDUCED

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

- the specific reasons for the denial;
- references to the provisions of the benefit plan or practice involved;
- a description of what additional information is necessary to perfect the claim and why;
- a copy of these procedures or comparable information about steps you need to take to resubmit it;
- 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.

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service urgent care claims</td>
<td>As soon as possible, but not later than 72 hours</td>
</tr>
<tr>
<td>Pre-service non-urgent claims</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Post-service claims</td>
<td>Within 60 days</td>
</tr>
</tbody>
</table>

Overpayments and Other Errors

If a benefit is paid that is larger than the amount payable under the Plan, the Plan has a right to recover the excess amount from the person or agency that received it. Erroneous payments or statements will not change the rights or obligations under the Plan and will not operate to grant additional benefits or coverage.

Subrogation

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

The medical and dental Plans reserve the “right of subrogation” in the event of a loss. The Plan Administrator or Plan Sponsor may choose to take action to recover the amount of a claim paid to you or your covered dependent if the loss was caused by a third party. The Plan shall be entitled to full reimbursement first from any payments by a potentially responsible party. If you have the right to receive such a payment from a third party, the Retiree Medical Plan can claim the payment directly from the party. This means, for example, that the Retiree Medical Plan is entitled to reimbursement from you or your covered dependent for the expenses that it paid on account of the injury or illness.

The Plan is not required to participate in or pay attorney fees to the attorney hired by the Plan participant to pursue the Plan participant’s damage claim.

Claims Appeals

Please see the
Contacts for Appeals section on page 70 for contact information.

Before beginning the appeals process, contact your carrier for a clearer explanation of the denial and provide additional information that may allow reconsideration of your claim. If, after contacting the appropriate carrier 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. This is considered a first level appeal (Level 1) and is performed by the carrier. 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 Corteva Connection.

You must make this request in a timely manner after you receive the original claim decision or after you receive a claim denial, but in no event later than 180 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. In deciding a medical, Rx, or dental Level 2 appeal of any adverse benefit determination that is not enrollment or eligibility related, the Plan Administrator shall refer the appeal to an external Independent Review Organization for review. The external review will be conducted by an independent health care professional who has appropriate training and experience in the field of medicine involved including determinations whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.

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

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

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Level 1 Appeal Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility and Enrollment</td>
<td>• Within 30 days</td>
</tr>
<tr>
<td>Medical</td>
<td>• 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;</td>
</tr>
<tr>
<td></td>
<td>• Within 15 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
<tr>
<td>Rx</td>
<td>• 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;</td>
</tr>
<tr>
<td></td>
<td>• Within 15 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
<tr>
<td>Dental</td>
<td>• As soon as possible, taking into account the circumstances that require action, but not later than 72 hours for pre-service urgent-care claims;</td>
</tr>
<tr>
<td>Type of Appeal</td>
<td>Level 1 Appeal Response Time</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Within 15 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
</tbody>
</table>

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

When you are notified of the decision on your appeal, the notice will provide the reason for the decision and the specific Plan provisions on which it is based.

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

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

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Level 2 Appeal Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility and Enrollment</td>
<td>• The Benefit Plan Appeals Committee will respond within 60 days</td>
</tr>
<tr>
<td>Medical</td>
<td>• Within 72 hours for pre-service urgent-care claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
<tr>
<td>Rx</td>
<td>• Within 72 hours for pre-service urgent-care claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 15 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
<tr>
<td>Dental</td>
<td>• Within 72 hours for pre-service urgent-care claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 15 days for pre-service claims;</td>
</tr>
<tr>
<td></td>
<td>• Within 30 days for post-service claims.</td>
</tr>
</tbody>
</table>

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**

When you are notified of the final decision, the notice will provide the reason for the decision and the specific Plan provisions on which it is based.

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);
- 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);
- 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.

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) 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, the following will apply:
▪ no deference will be afforded to the initial adverse determination;
▪ the review will be conducted by an appropriate 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.

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 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 within 12 months (the "Limitations Period") following the date the final adverse benefit determination is issued. Notwithstanding the foregoing, if you fail to engage in or exhaust the 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). 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.
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.
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 for additional important details.

- For the Retiree Medical Plan and Dental Plan (including the HRA accounts), you or your dependent losing coverage may have the option to continue coverage, under COBRA.

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 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.

COBRA Also Applies to the Health Reimbursement Arrangement (HRA)

Please note that if coverage is lost because of death, divorce, or loss of dependent status, the Health Reimbursement Arrangement can be continued under COBRA.

What Is COBRA Continuation Coverage?

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

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

- Your spouse dies; or
- You become divorced or legally separated from your spouse.

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

- The parent-retiree dies;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

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

When Is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Corteva Connection has been notified that a qualifying event has occurred. Corteva Connection will be automatically notified in the event there is a commencement of a proceeding in bankruptcy with respect to the employer.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS
For the other qualifying events listed below, you must notify Corteva Connection within 60 days after the qualifying event occurs.

- Divorce or legal separation of the retiree and spouse
- A dependent child’s losing eligibility for coverage as a dependent child

For Medicare eligible participants with a Company provided HRA, COBRA is administered by Via Benefits.

How Is COBRA Coverage Provided?
Once Corteva Connection (or Via Benefits for Medicare eligible participants with a Company funded HRA) 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 retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

<table>
<thead>
<tr>
<th>Reason Regular Coverage Ends</th>
<th>How Long COBRA Coverage Can Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment with the Company ends for any reason other than gross misconduct</td>
<td>18 months</td>
</tr>
<tr>
<td>Your regularly scheduled work hours are reduced, making you ineligible for coverage</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>29 months</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>36 months (for dependents)</td>
</tr>
<tr>
<td>You die</td>
<td></td>
</tr>
<tr>
<td>You divorce, have your marriage annulled or legally separate</td>
<td></td>
</tr>
<tr>
<td>Your dependent stops being eligible for coverage</td>
<td></td>
</tr>
</tbody>
</table>

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 the Corteva Connection (or Via Benefits for Medicare eligible participants with a Company funded HRA) 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 Corteva Connection within the first 60 days of COBRA coverage.
SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if Corteva Connection is notified within 60 days about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. To notify Corteva Connection of the additional qualifying event, call 1-800-775-5955.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your Company coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you, whichever is later. You must pay 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 Corteva Connection at 1-800-775-5955. (Medicare eligible participants with a Company provided HRA should contact Via Benefits with questions.) For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

HIPAA Certification

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employers to provide certification showing evidence of your prior health coverage when you are no longer eligible for coverage. The certificate is included with the COBRA application package the HR Service Center sends you.
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 the benefits.

“Corteva” and the “Company”
- Where we use “Corteva” in this summary, we mean E.I. du Pont de Nemours and Company, a subsidiary of Corteva, Inc.
- Where we refer to the “Company” in this summary, we mean an organization affiliated with Corteva, Inc. that has adopted or participates in the Retiree Medical and Dental Plans and previously employed you.

Medicare Advantage Health Plan
A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Most Medicare Advantage Plans also provide prescription drug coverage.

Medicare Supplement Plan
A Medicare Supplement Insurance (also called Medigap) policy helps pay some of the health care costs that Original Medicare doesn’t cover, such as copayments, coinsurance and deductibles. Medicare Supplement Plans are sold by private companies. A Medicare Supplement Plan is designed to supplement Medicare coverage.

Retiree
A “Retiree” is a terminated employee of the Company who is eligible to receive post-employment Retiree Medical Plan and/or Dental Plan benefits.

Survivor
For purposes of the retiree Medical and Dental Plans, a Survivor is the person (or people) who receive the remaining value of a retiree’s vested Pension Plan benefit upon death of the retiree.

See the rules for Survivor benefits under your Title in the Pension and Retirement Plan Summary Plan Description, “Pension and Retirement Plan,” for more information.
Administrative Information

ERISA Rights
As a participant in any of the Plans described in this summary, 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 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 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 Corteva 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 65.

Agent for Service of Legal Process

Legal process may be served on:

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

Legal process may also be served on the Plan Administrator.

Administrative Plan Details

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

E. I. du Pont de Nemours and Company
974 Centre Road
Wilmington, DE 19805
Phone: 1-302-774-1000

The Employer Identification Number (EIN) for all the plans covered in this summary is 51-0014090.

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

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

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

Benefit Plan Appeals Committee
974 Centre Road
Wilmington, DE 19805
Phone: 1-302-774-1000

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

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 Retiree Medical Program

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>The Retiree Medical Program</th>
</tr>
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<tbody>
<tr>
<td>Plan Number</td>
<td>519</td>
</tr>
<tr>
<td>Type of Plan</td>
<td>The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits.</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>The Claims Administrators vary by location. For the Core and Premium Saver Options, the Claims Administrators are: Aetna, Inc. P.O. Box 14079 Lexington, KY 40512 1-800-938-7668 Highmark BCBS Delaware P.O. Box 1991 Wilmington, DE 19899-1991 1-888-431-4650 Triple S P.O. Box 363628 San Juan, PR 00936-363628 1-787-774-6060 Via Benefits 1975 S. Sterling View Dr. South Jordan, UT 84095 1-855-535-7140</td>
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<td>Source of Benefits Funding</td>
<td>You and the Company pay the cost.</td>
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The Dental Assistance Plan

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<th>The Dental Assistance Plan</th>
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<tr>
<td>Plan Number</td>
<td>507</td>
</tr>
<tr>
<td>Type of Plan</td>
<td>The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits.</td>
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<tr>
<td>Claims Administrator</td>
<td>MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-888-883-0052</td>
</tr>
<tr>
<td>Source of Benefits Funding</td>
<td>You and the Company pay the cost.</td>
</tr>
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</table>
# Contacts

<table>
<thead>
<tr>
<th>For Help with</th>
<th>Contact</th>
</tr>
</thead>
</table>
| Eligibility and Enrollment or COBRA Coverage | Corteva Connection  
1000 S. Perimeter Rd  
P.O. Box 7101  
Rantoul, IL 61866-7101  
http://digital.alight.com/ Corteva  
1-800-775-5955  
Via Benefits (for Medicare eligible participants with a Company funded HRA)  
10975 S. Sterling View Dr.  
South Jordan, UT 84095  
1-855-535-7140 |
| Medical Benefits | Aetna, Inc.  
P.O. Box 14079  
Lexington, KY 40512  
1-800-938-7668  
www.aetna.com  
Highmark BCBS Delaware  
P.O. Box 1991  
Wilmington, DE 19899-1991  
1-888-431-4650  
www.highmarkbcbsde.com  
Triple S  
P.O. Box 363628  
San Juan, PR 00936-363628  
1-787-774-6060  
www.ssspr.com |
| Choosing Providers | Castlight  
1-855-572-2172  
www.mycastlight.com/ Corteva |
| HRA (Health Reimbursement Account) Or HRA COBRA Coverage | Via Benefits  
10975 S. Sterling View Dr.  
South Jordan, UT 84095  
1-855-535-7140  
My.ViaBenefits.com |
| Pharmacy Benefits | CVS Caremark  
1-844-212-8696  
www.caremark.com |
| Specialty Medications | CVS Speciality  
1-800-237-8767 |
| Mental Health/ Chemical Dependency Benefits | ComPsych  
1-838-787-7771  
www.guidanceresources.com |
<table>
<thead>
<tr>
<th>For Help with ...</th>
<th>Contact ...</th>
</tr>
</thead>
</table>
| Telephone medical consultation for minor illness or injury | Teladoc  
1-800-835-2362  
www.teledoc.com/Corteva |
| Dental Benefits | MetLife Dental  
P.O. Box 981282  
El Paso, TX 79998-1282  
1-888-883-0052  
www.metlife.com/mybenefits |
## Contacts for Appeals

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Contact Details</th>
</tr>
</thead>
</table>
| Eligibility and Enrollment | **Corteva Connection:** Benefit Determination Review Team  
                          | P.O. Box 1407  
                          | Lincolnshire, IL 60069-1407 |
| Dependent Verification  | **Corteva Connection:** Dependent Verification Center  
                          | P.O. Box 1415  
                          | Lincolnshire, IL 60069-1415 |
| Medical                 | **Aetna:**  
                          | *For standard appeals:*  
                          | Aetna Customer Resolution Team  
                          | P.O. Box 14463  
                          | Lexington, KY 40512 |
|                         | *For pre-service appeals:*  
                          | Aetna Customer Resolution Team  
                          | P.O. Box 14001  
                          | Lexington, KY 40512 |
|                         | **Highmark:**  
                          | Highmark Blue Cross Blue Shield Delaware  
                          | Attention: Customer Service Appeals Team  
                          | P.O. Box 8832  
                          | Wilmington, DE 19899-8832  
                          | Fax: 877-710-1513 |
|                         | **ComPsych:**  
                          | ComPsych Appeals Coordinator  
                          | 455 N Cityfront Plaza Drive, 13th Floor  
                          | Chicago, IL 60611 |
|                         | **Triple S:**  
                          | Claims and Appeals  
                          | P.O. Box 363628  
                          | San Juan, PR 00936-363628  
<pre><code>                      | disputedclaims@opm.gov |
</code></pre>
<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Contact Details</th>
</tr>
</thead>
</table>
| Rx            | • CVS Caremark  
              Appeals Department, MC 109  
              PO Box 52084  
              Phoenix, AZ 85072-2084  
              Fax: 866-443-1172  

• Clinical Exceptions / Medical Necessity Requests  
  Fax: 888-487-9257  

  Urgent Verbal Exception  
  Phone: 877-203-1681  

• External Review Appeals Department MC 109  
  PO Box 52084  
  Phoenix, AZ 85072-2084  
  Fax: 866-443-1172  

Dental        | MetLife Group Claims Review  
              P.O. Box 14589  
              Lexington, KY 40512 |
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