CORTEVA™
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YOUR BENEFIT SUMMARY

RETIREE MEDICAL PLAN

About this Summary

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

While the Company intends to continue the Plan described in this summary, the Company reserves the right to change, modify or discontinue the Plan and any component of the Plan at its discretion at any time. If the Plan is terminated, only benefits accrued through the effective date of the termination will be paid. There is no guarantee of lifetime benefits under the Plan. No person has or will have a vested or nonforfeitable right to receive benefits under the Plan.

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

YOUR BENEFIT SUMMARY

Retiree Medical Plan

JANUARY 2024

Corteva's retiree medical benefit offers comprehensive and robust pre-Medicare coverage to eligible retirees, survivors, and dependents. The plan 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.

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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 Plan if you are a retiree or Survivor from a Company that has adopted the Plan for former employees. Newly retiring employees must meet the eligibility requirements outlined 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 Plan benefits. If you have questions regarding your eligibility, contact Corteva Connection.

If you began working for DuPont de Nemours, Inc. or an affiliated company on June 1, 2019 in connection with the spin-off of the Specialty Products Division of DowDuPont, Inc., you will be eligible for the Retiree Medical Plan only if you met all eligibility requirements as of May 31, 2019. Solae, Danisco, Genencor and MECS companies ceased participation in the plan as of May 31, 2019. For those retirees to be eligible they must have met all eligibility requirements as of May 31, 2019.

Company	Eligibility Requirements
Corteva (Including Puerto Rico subsidiaries)	You qualify for Retiree Medical 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 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 Plan 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.
Danisco	Note that Danisco retirees receive post-employment medical continuation coverage (COBRA) in the Medical Plan instead of the Retiree Medical Plan, with coverage ending at age 65.
Genencor	You qualify for Retiree Medical Plan 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.
MECS, Inc.	You qualify for Retiree Medical Plan coverage if you were: • hired before May 1, 2022* and • at least age when you retired with at least 10 years of service.

** 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 plan through Via Benefits to receive the HRA. See “After Becoming Eligible for Medicare” on page 7 for more information.

Eligible Dependents

For the Retiree Medical 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 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 Claim’s Administrator; and
      - you claim the child as your dependent on your federal income tax return.

Eligible Child Survivors

Coverage for a Survivor who is a minor child will end on the last day of the month in which the child becomes age 21. COBRA continuation is available.

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 Plan 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. Additionally, 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 on the previous page. 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.

Questions?

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

How to Enroll

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

Important information about opting out of coverage can be found under “When You Drop Coverage” on page 9. 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 at retirement through COBRA (generally for up to 18 months), instead of enrolling in the Retiree Medical Plan. 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 coverage. Electing COBRA coverage instead of retiree coverage is permanent and irrevocable (except for Solae employees whose employment ended under the Career Transition Program and before May 31, 2019).

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 as shown below. These Plans provide coverage until you are eligible for Medicare.

If you reside in…	You will automatically be enrolled in…
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. If you were enrolled in a PPO Copay Plan while you were an active employee, you will be automatically enrolled in the Core Option.
Puerto Rico	• The Retiree Medical Plan Alternative Coverage Option with Triple S as the carrier.
Hawaii	• The Retiree Medical Plan Core Option. HMSA is not available through the Retiree Medical Plan. If you wish to elect the Core or Premium Saver 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.

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 creditable health plan. See “Changing Your Coverage” on page 9 for more information.

Solae

Retirees or covered dependents from Solae end their Plan coverage when they become eligible for Medicare or reach age 65.

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 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 once they are eligible for Medicare.
  - Individuals who become eligible for Medicare at age 65 will automatically have their pre-Medicare Retiree Medical 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 30 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 will 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.
  - 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.
- 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 9 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 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 plan you purchase locally.

Paying for Coverage

The premiums for the Retiree Medical 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 continues through the end of the month. Your participation in the Retiree Medical 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 stepchild), 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 2024, those changes are effective on January 1, 2025.

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 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 within 60 days of losing eligibility for your coverage in another creditable health plan, after having been continuously covered by another creditable health plan while you were not covered in the Retiree Medical Plan

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 creditable 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 coverage for yourself or your dependents is permanent and cannot be changed. If you decline medical 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 30). 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 coverage.

If you decline coverage for yourself, you cannot later enroll in the Retiree Medical Plan unless you were continuously covered in another creditable 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 creditable health coverage. Loss of coverage cannot be because of nonpayment of premiums. Re-enrollment must occur with 60 days of the date creditable health 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 creditable 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).

Your Decision to Decline Retiree Health Coverage Is Permanent

It is important to note that once you elect to discontinue your retiree medical coverage, you will not be able to enroll in the Plans later. In general, declining coverage is a permanent and irrevocable action. Retiree medical coverage can only be reinstated if you lose eligibility for other creditable health coverage.

What Happens If…

Your Are Rehired by the Company

If you are eligible for Retiree Medical 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 plan. You can re-enroll in retiree coverage when you lose eligibility for the Company's active employee group medical plan, 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 plan through Via Benefits. See "After Becoming Eligible for Medicare" on page 7 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 plan through Via Benefits. See "After Becoming Eligible for Medicare" on page 7 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' 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.

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

If you or your spouse have medical coverage from another employer's plan and that coverage ends, you can enroll yourself and/or your spouse for Company medical 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. See the rules for Survivor benefits under the 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 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.

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" on page 46.

	Core Option		Premium Saver Option	
Medical Care Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (annual amount, combined for medical and prescription drug claims)	$1,750 for you only coverage	$3,500 for you only coverage	$3,000 for you only coverage	$4,500 for you only coverage
	$3,500 for other coverage levels	$7,000 for other coverage levels	$6,000 for other coverage levels	$9,000 for other coverage levels
Preventive Care (see your medical carrier for a list of covered services)	100% paid, no deductible	100% paid based on R&C, no deductible	100% paid, no deductible	100% paid based on R&C, no deductible
Coinsurance for medical services • Office visits • Mental health care • Chiropractic care ($1,000 annual limit) • Labs and X-Rays • Hospitalization • Surgery	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible
Prescription Cost Sharing The deductible is waived for medications on the preventive medication list (see "Preventive Medications" on page 26) • Retail benefits apply to a single fill up to a 30-day supply; • Mail-Order benefits apply to a single fill of up to a 90-day supply. • Additional information regarding prescription drugs appears under "Prescription Drugs" on page 24.				
Generic	No charge after deductible			
Brand Formulary (Preferred)	You pay 25% after deductible; $125 maximum* per fill			
Brand Non-Formulary (Non-Preferred)	You pay 45% after deductible; $250 maximum* per fill			
Specialty	PrudentRx-eligible: You pay 30% coinsurance after deductible OR $0 after deductible if enrolled in PrudentRx Non-PrudentRx-eligible: Applicable coinsurance applies			
Maintenance medications after second fill at retail pharmacies	If you fill a maintenance medication more than two times at a retail pharmacy other than CVS, you will pay 100% of the cost**.			
Out-of-Pocket Maximum (annual amount, combined for medical and prescription drug claims)	$5,000 per person	$10,000 per person	$6,000 per person	$12,000 per person
	$10,000 for all family members combined	$20,000 for all family members combined	$12,000 for all family members combined	$24,000 for all family members combined

**Rx maximum coinsurance amounts are per prescription*

***The amount you pay for maintenance medications filled more than two times at a retail pharmacy other than CVS does not apply toward the deductible and out-of-pocket maximum. Even if you've reached your deductible and out-of-pocket maximum, you still pay the full cost for maintenance medications filled more than twice at a retail pharmacy other than CVS.*

Your Deductible Applies to Medical and Prescription Drug Services

The Plan uses a combined deductible for medical and prescription drug. 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.)

- The medical Claims Administrator is Highmark BCBS.
- Prescription drug claims are administered through CVS Caremark.

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 44.

If You Waive Coverage

If you decline post-employment medical coverage for yourself or your dependents, you cannot change this election at a later date unless you lose eligibility for other creditable health coverage. See "When You Drop Coverage” on page 9 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:

2024 Standard Monthly Premium Rates for Retirees			
Coverage Level	Core Option	Premium Saver Option	Alternative Coverage Option for Solae, MECS and Puerto Rico
You Only	$401.88	$338.15	Call Corteva Connection at 1-800-775-5955 for Premium Information and Medical Options
You + Spouse	$808.85	$671.36	
Other coverage levels	Call Corteva Connection for rates		

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.

Effective January 1, 2022, the company contribution to retiree medical plan has been frozen and all future cost increases will be absorbed by the retiree.

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.

How Coverage Works

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

Option	Premiums	Deductible	Out-of-Pocket Maximum
Core Option	Higher	Lower	Lower
Premium Saver Option	Lower	Higher	Higher
Alternative Coverage Options for Solae, MECS and Puerto Rico	Contact your carrier for plan design and coverage details		

See the “Highlights: Pre-Medicare Options” chart on page 11 for a comparison of the Core and Premium Saver Options.

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 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.

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 26 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 16 for more information.
- See “What Is Covered” on page 18 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)

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!

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
- the mental health and chemical dependency network; and
- the prescription drug retail, mail and specialty pharmacy network.

Refer to “Contacts” page 46 for a list of carriers and their contact information. Or contact your carrier using the information printed on your medical and pharmacy ID cards.

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.

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 Highmark BCBS 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.

	Core Option		Premium Saver Option	
Medical Care Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (annual amount, combined for medical and prescription drug claims)	$1,750 for you only coverage $3,500 for other coverage levels	$3,500 for you only coverage $7,000 for other coverage levels	$3,000 for you only coverage $6,000 for other coverage levels	$4,500 for you only coverage $9,000 for other coverage levels

The annual deductible applies to most covered services, such as: office visits, prescription medications, mental health and chemical dependency care, and emergency care. The deductible is waived for covered preventive care (as described under Preventive Care 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.

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

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

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

Prescription Cost Sharing	Core Option	Premium Saver Option
Generic	No charge after deductible	
Brand Formulary (Preferred)	You pay 25% after deductible; $125 maximum per fill	
Brand Non-Formulary (Non-Preferred)	You pay 45% after deductible; $250 maximum per fill	
Specialty	PrudentRx-eligible: You pay 30% coinsurance after deductible OR $0 after deductible if enrolled in PrudentRx Non-PrudentRx-eligible: Applicable coinsurance applies	
Maintenance medications after second fill at retail pharmacies	If you fill a maintenance medication more than two times at a retail pharmacy other than CVS, you will pay 100% of the cost.	
See “Prescription Drugs” on page 24 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.

	Core Option		Premium Saver Option	
Medical Care Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Maximum (annual amount, combined for medical and prescription drug claims)	$5,000 per each person	$10,000 per each person	$6,000 per each person	$12,000 per each person

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 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, the Plan will pay 100% for all covered family members' care for the rest of the year.

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.

Expenses that count toward your annual out-of-pocket maximum include deductible and coinsurance amounts for medical and prescription coverage, except as noted below. These expenses do not apply to the annual medical out-of-pocket maximum:

- 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

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

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

Lifetime Maximum Benefits

The lifetime maximum benefit is the limit the Plan will pay in each covered person's lifetime. The Plan has no general lifetime maximum benefit; however, infertility services and in-vitro fertilization procedures shall not exceed a lifetime family maximum of $15,000 for infertility medical treatments and $10,000 for infertility prescription drugs. Expenses incurred under the lifetime infertility benefits are cumulative.

- If you use these services and later use them again, the earlier charges will continue to apply toward the lifetime maximum.
- If you change to a different 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

Precertification is recommended for the following services:

- all mental health and chemical dependency care
- 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 pre-certified, you or your treating physician should contact your medical carrier 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 pre-certify 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 27.

PREVENTIVE CARE

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

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

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

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

Preventive Care Services Covered at 100%

The Plan covers many preventive care services at 100% with no deductible or coinsurance. For a complete list of covered preventive care services, as well as age and frequency limits, contact your medical carrier. Note: Reasonable and customary limits apply for preventive care received out-of-network.

Preventive Screenings and Exams

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

- routine preventive physical exams given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury
- breast cancer and cervical cancer screenings
- colon cancer screenings, including a pre-screening consultation, removal of polyps, and the pathologic exam of a polyp biopsylactation 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 his 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 Well360 Virtual Health 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 22 for more information)
- allergy testing and treatment
- chiropractic care by a licensed provider
  - Services limited to X-rays and manipulations of the spine, heat and ultrasound, therapeutic procedures and activities, traction and electrical stimulation. Services must be medically "necessary and restorative" in nature. Charges for services specifically to maintain a level of well-being are not covered. Benefits are limited to a maximum of $1,000 per person per plan year.
- gynecological care

The Convenience of Well360 Virtual Health

Well360 Virtual Health 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 Well360 Virtual Health at **www.myhighmark.com/Corteva**. At $64 per visit, a Well360 Virtual Health doctor is significantly less expensive than urgent care and emergency room visits.

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.

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

Women's Health and Cancer Rights Act

The medical Plan complies with the provisions of the Women's Health and Cancer Rights Act concerning coverage for reconstructive surgery in connection with mastectomies. Specifically, the Medical Plan covers:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

Urgent Care and Emergency Care

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

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

Urgent Care

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

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

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.

Emergency Care

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

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

Examples of emergencies are:

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

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

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

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

Outpatient Surgery and Treatment

Covered services include:

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

Hospitalizations and Other Inpatient Services

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

- hospital services
  - inpatient room and board coverage is for a semi-private room. If you stay in a private room, you pay the difference between its cost and the average cost of a semi-private room in that hospital.
  - inpatient operating and recovery room
  - inpatient ancillaries (supplies, tests, medications, therapies, etc.)
- Christian Science facility (in-network coverage may not be available in all areas)
  - Care must qualify as medically necessary, using the same standards applicable to other hospital care.
- extended-care facility
  - Limited to medically necessary skilled-care needs related to a recent hospital confinement as approved in advance by your medical carrier.
- inpatient short-term rehabilitation (physical, occupational and speech therapy)
  - Limited to “restorative therapy”, except for certain developmental coverage for children or physical therapy for some neurological diseases such as Multiple Sclerosis, Cerebral Palsy, Polio, Spina Bifida, Amyotrophic Lateral Sclerosis, 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 In vitro fertilization (IVF) benefits are available regardless of fertility or vasectomy status. Freezing of egg or sperm is covered only for cancer patients going through chemotherapy/radiation.

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, genital reconstructive surgery, trachea shave/thyroid chondroplasty, chin augmentation and facial bone reduction/facial feminizing.

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

Hospice Care

The Plan covers hospice care for terminally ill patients in the final stage of an incurable illness. Services must be in an approved, licensed hospice facility or program. Call your medical carrier to pre-certify hospice care. See “Precertification” on page 17 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.

TRAVEL BENEFITS

Reimbursement of certain eligible travel and lodging expenses associated with and necessary to obtain any eligible plan medical services when those services are unavailable within 50 miles of the covered individual's home. Subject to a lifetime maximum of $5,000.

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/carrier 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, CVS Specialty. 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.

Pharmacy ID Cards

Highmark participants will receive prescription drug ID cards from CVS Caremark. If you present your ID card at a CVS participating network retail pharmacy, you can receive up to a 30-day supply of your prescription for a discounted price. You must show your ID card when you go to have your prescription filled to receive in-network pharmacy benefits.

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.
- To ensure you're taking advantage of the most efficient means to fill these prescriptions, you will be required to use either a CVS pharmacy or the mail-order pharmacy after your second refill. You can fill a maintenance prescription twice at any retail pharmacy and receive coverage. After the second refill, though, you must use either a CVS pharmacy or order the prescription through mail-order. If you fill it for a third time at a retail pharmacy other than CVS, it will not be covered, and you will pay 100% of the cost.
- Specialty medication will only be covered when purchased through the Plan's specialty medication provider, see "Specialty Medications" on page 26 for additional information.
- When taking a newly prescribed medication, it is 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.

- 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**.
- 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).
- 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

Type of Medication	Amount You Pay For up to a 30-day supply at retail or 90-day supply at mail order
Preventive Medications designated by the Affordable Care Act, including: • Generic Contraceptives • Smoking cessation medications • Colonoscopy bowel preps	Free
Preventive Medication List	No deductible applies. Co-insurance may apply depending upon type of drug dispensed.
Generic	Free after meeting the deductible
Brand Formulary (Preferred)	25% coinsurance after deductible; $125 maximum
Brand Non-Formulary (Non-Preferred)	45% coinsurance after deductible; $250 maximum
Maintenance medications filled more than two times at retail pharmacies	Not covered

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 any of your medication is classified as preventive, go to the CVS Caremark website at **www.caremark.com**.

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. 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 CVS Specialty. It is your responsibility to ensure your physician orders specialty medications to be administered on an outpatient basis through CVS Specialty. 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 CVS Specialty. Specialty medications administered while you are an inpatient are processed as medical (rather than pharmacy) claims by your medical claims administrator.

PrudentRx Program for Specialty Drugs

You will be automatically enrolled in the PrudentRx Program but can opt out. PrudentRx eligible specialty drugs are covered with $0 cost sharing. If you choose to opt out or fail to enroll in any copay assistance as required by a manufacturer, you are responsible for the 30% coinsurance for PrudentRx eligible drugs. Copays for these medications (made by you/the plan/assistance program) will not count. Because certain specialty medications do not qualify as “essential health benefits” under the ACA, your cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards your out-of-pocket limit.

Coverage Management Programs

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

- Prior Authorization Requires you to obtain approval through a coverage review. A coverage review is performed to determine whether the use of the medication qualifies for coverage.
- Preferred Drug Step Therapy Program Requires you to use the generic or preferred brand before a non-preferred brand is covered. Selected non-preferred brands must undergo a coverage review and be approved before the non-preferred brand is covered.
- Dose Duration rules encourage appropriate dosing over the course of therapy. Coverage is determined based on drug history. A prescription that exceeds the dosage allowed within a given time period will require a coverage review.
- Quantity Duration rules limit coverage for certain quantities of medications within a defined time period. A prescription that exceeds the quantity allowed will require a coverage review (if available) and approval to obtain the excess amount.
- Dispensing Quantity rules allow up to a maximum quantity per copayment. A prescription that exceeds the quantity allowed per copayment will require a coverage review, or you may pay another copayment for the additional medication.
- Dose Optimization rules focus on switching those members currently taking two tablets or capsules a day to taking one a day of the higher strength. A coverage review is required (if available) to determine whether taking one tablet or capsule each day of the higher strength is right for the member.

Drug Utilization Review

Your drug benefit includes an important safety feature. Participating retail pharmacies and the mail service pharmacists access a computerized database to check each prescription against a record of other drugs you have purchased through this program. The system alerts the pharmacist to any potential drug interactions. It also provides an alert on the appropriateness of a limited number of specialized drugs.

If there is a question, the pharmacist will work with your doctor before dispensing medication. However, you should always tell your doctor about your current medications before beginning a new drug.

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 must be 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 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 a tax-advantaged 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 an 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. You always own the money in your HSA, including contributions provided by Corteva while you were an active employee. You can use the money in the HSA to pay for future out-of-pocket health care expenses for you and your tax dependents. You can take the account with you if you retire or leave the Company.

To open an optional, tax-free personal 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.

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.

HSA PLAN LIMITS

For 2024, the HSA contribution limits will be as follows:

- single $4,150
- family $8,300
- If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 annually.

ELIGIBLE HSA EXPENSES

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

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

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

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 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” staring on page 6 for details.

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.

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.

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 31.

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.

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:

	Corteva	Corteva Puerto Rico (DACI, DEMI)	Pioneer	Genecor	MECS
Annual HRA Amount per person	$1,200 medical	$1,200 medical	$1,200 medical	$1,200 medical	$1,400 medical
Prorated for early retirement?	Yes	No	No	Yes	Yes, if less than 25 years of service at retirement

Prorated HRA Contributions for Corteva and Genencor (grandfathered employees)

The Company's HRA contribution is based on your age and service at the time of retirement. Call Corteva Connection if you have questions about your proration factor.

Your HRA Company contribution may differ from those shown above based on various factors such as your Company, age and service at retirement. 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 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 plan through Via Benefits is waived while you live outside the Via Benefits sales footprint. If you move to the U.S., you will be required to buy a medical plan through Via Benefits in order to continue to receive an HRA from Corteva.

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

Type of Care/Claim	How to File
Medical Care (Core and Premium Saver Options) *From an in-network provider*	• You don't need to file claims if you use a network provider. Your network provider will file the claim for you. • Your provider may ask you to pay your share of the claim costs when you receive the care or they may bill you. • Don't forget that some care must be pre-certified.
Medical Care (Core and Premium Saver Options) *From an out-of-network provider*	• For out-of-network services, the best method is to bring a claim form with you when you need care. In some cases, your provider or facility may submit the claim form on your behalf. You can get claim forms from the carrier website. – Alternatively, you can file a claim after you've received the care. In this case, you would 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).

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 46.

IF YOU HAVE OTHER COVERAGE

If you or a covered dependent is also enrolled in another 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.

How to 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.

Coordination of Benefits with Medicare

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

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:

	Medical
Pre-service urgent care claims (when you await treatment pending the outcome of the claim decision and your health would be severely jeopardized if the claim were not handled in an urgent manner)	As soon as possible, taking into account the health circumstances that require action. Your carrier will contact you within 72 hours.
Pre-service non-urgent claims	Within 15 days
Post-service claims	Within 30 days

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:

	Medical
Pre-service urgent care claims	As soon as possible, but not later than 48 hours
Pre-service non-urgent claims	Within 45 days
Post-service claims	Within 45 days

IF A CLAIM IS DENIED OR REDUCED

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

- the specific reasons for the denial;
- references to the provisions of the benefit plan or practice involved;
- a description of what additional information is necessary 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:

	Medical
Pre-service urgent care claims	As soon as possible, but not later than 72 hours
Pre-service non-urgent claims	Within 30 days
Post-service claims	Within 60 days

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 Retiree Medical Plan reserves 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 Retiree Medical 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 Retiree Medical Plan is not required to participate in or pay attorney fees to the attorney hired by the Retiree Medical Plan participant to pursue the Retiree Medical Plan participant's damage claim.

Claims Appeals

Please see the "Contacts for Appeals" section on page 47 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 or Rx.

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:

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

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:

Type of Appeal	Level 2 Appeal Response Time
Eligibility and Enrollment	• The Benefit Plan Appeals Committee will respond within 60 days
Medical	• Within 72 hours for pre-service urgent-care claims; • Within 30 days for pre-service claims; • Within 30 days for post-service claims.
Rx	• Within 72 hours for pre-service urgent-care claims; • Within 15 days for pre-service claims; • Within 30 days for post-service claims.

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 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. If you fail to file such suit or legal action within the Limitations Period, you will lose any rights to bring any such suit or legal action thereafter.

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 (including the HRA accounts), you or your dependent losing coverage may have the option to continue coverage, under COBRA.

Keep Your Plan Informed of Address Changes

To protect your family’s rights, keep the Plan Administrator informed of any changes in the addresses of family members. Also keep a copy, for your records, of any notices you send to the Plan Administrator. To report an address change, contact Corteva Connection at 1-800-775-5955.

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.

Reason Regular Coverage Ends	How Long COBRA Coverage Can Last
• Your employment with the Company ends for any reason other than gross misconduct • Your regularly scheduled work hours are reduced, making you ineligible for coverage	• 18 months
• You or your dependent is disabled (as determined by the Social Security Administration) before the 60th day of COBRA continuation coverage and continues to be disabled at least until the end of the 18-month period of COBRA continuation coverage.	• 29 months
• You become entitled to Medicare • You die • You divorce, have your marriage annulled or legally separate • Your dependent stops being eligible for coverage	• 36 months (for dependents)

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify 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 are 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 used throughout the 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 EIDP, Inc. or prior to January 1, 2023, 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 Plan 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 Program benefits.

SURVIVOR

For purposes of the Retiree Medical Plan, 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 qualifies status of a court order, you can file suit in a federal court. If the 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 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 a 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 43.

Agent for Service of Legal Process

Legal process may be served on:

EIDP, Inc.

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:

EIDP, Inc.
974 Centre Road
Wilmington, DE 19805
Phone: 1-833-267-8382

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 (EIDP, Inc.)
974 Centre Road
Wilmington, DE 19805

The Plan Administrator for purposes of appeals of claims only is:
Benefit Plan Appeals Committee (EIDP, Inc.)
974 Centre Road
Wilmington, DE 19805
Phone: 1-833-267-8382

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 Plan

Plan Name	The Retiree Medical Plan
Plan Number	519
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits.
Claims Administrator	The Claims Administrators vary by location. For the Core and Premium Saver Options, the Claims Administrators are: Highmark BCBS Delaware P.O. Box 1991 Wilmington, DE 19899-1991 1-833-599-5657 For Puerto Rico the Claims Administrator is: Triple S P.O. Box 363628 San Juan, PR 00936-363628 1-787-774-6060 For HRA benefits the Claims Administrator is: Via Benefits 10975 S. Sterling View Dr. South Jordan, UT 84095 1-855-535-7140
Source of Benefits Funding	You and the Company pay the cost.

Contacts

For Help With…	Contact…	
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	Highmark BCBS Delaware P.O. Box 1991 Wilmington, DE 19899-1991 1-833-599-5657 www.highmarkbcbsde.com	Triple S P.O. Box 363628 San Juan, PR 00936-363628 1-787-774-6060 www.ssspr.com
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 Specialty 1-800-237-2767 www.cvsspecialty.com	PrudentRx 1-800-578-4403 www.prudentrx.com
Telephone medical consultation for minor illness or injury	Well360 Virtual Health 1-866-883-7358 www.myhighmark.com	

Contacts for Appeals

Type of Appeal	Contact Details	
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	Highmark: Highmark Blue Cross Blue Shield Delaware Attention: Customer Service Appeals Team P.O. Box 8832 Wilmington, DE 19899-8832	Triple S: Claims and Appeals P.O. Box 363628 San Juan, PR 00936-363628 disputedclaims@opm.gov
Rx	CVS Caremark Appeals Department, MC109 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 MC109 PO Box 52084 Phoenix, AZ. 85072-2084 Fax: 866-443-1172	