Your Benefit Summary

DuPont Special Benefits Plan

Effective January 1, 2023

About this Summary

This Summary Plan Description (SPD) provides a concise description of the DuPont Special Benefits Plan (the "Special Benefits Plan" or the "Plan"). This SPD is intended to help you understand your benefits, how the Plan operates, how to file claims, and your rights and responsibilities as a participant. While this summary contains detailed and important information about your Plan benefits, we've tried to make it clear and easy to understand. To receive benefits or to ensure that your beneficiary receives benefits, you will need to satisfy the requirements that are described in this summary.

This summary does not describe every feature in the Plan and it is not intended to be a full statement of the official plan document. In the event of a discrepancy between this summary and the official plan document, the applicable official plan document will govern and the Plan Administrator has the full discretion to interpret those documents.

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

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

See " Defined Terms" on page 9 for the meanings of certain capitalized terms used in this summary.

YOUR BENEFIT SUMMARY

DuPont Special Benefits Plan

JANUARY 2023

The Special Benefits Plan provides benefits if you get injured, become ill or die as a result of and in the course of your employment with the Company.

The Special Benefits Plan pays the difference between your Pay and Workers' Compensation for up to six months while you're disabled. It can also provide certain medical and surgical benefits not paid under Workers' Compensation or similar laws, or other Company plans, as well as special training, survivor benefits, and other awards.

Note: As previously communicated in April 2022, this Plan will terminate on April 30, 2023.

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Highlights

This table highlights key features of the Plan. Read the full SPD for more details.

Company-Provided Benefit	▪ The Company provides coverage at no cost to you (benefits are taxable when received). ▪ No enrollment is needed. ▪ Coverage begins automatically as soon as you are eligible.
Types of Claims Covered	▪ The Special Benefits Plan provides benefits if you are disabled or die because of your work for the Company. ▪ The Plan does not cover disabilities or death related to other work, such as if you have a second job or are self-employed.
Benefits for Disability	▪ 100% of your Pay, when combined with income from other sources, including Workers' Compensation. ▪ All benefits are taxable as regular pay. ▪ Benefits can continue for up to 6 months.
Reporting Your Disability	▪ Contact your supervisor and follow any other local reporting processes, and ▪ Call the Disability and Leave Center at 1-855-267-4402, to determine whether you qualify for benefits.
Death and Other Benefits	▪ The Plan may provide funeral expense benefits. ▪ The Plan may also provide special medical and surgical benefits as well as training.

Eligibility and Enrollment

Who's Eligible

You are eligible for the coverage described in this SPD if you are classified by the Company as an employee of the Company.

If you are an employee in a bargaining unit represented by a union for collective bargaining, you will not be eligible unless and until the site manager has authorized the benefit, collective bargaining on the coverage has taken place, and any requisite obligations thereunder have been fulfilled.

Broad Eligibility

All employees of the Company are eligible for this Plan, including: Full-Time and Part-Time Employees, and Seasonal Employees.

Automatic Enrollment

You do not need to enroll or provide proof of good health—if you are eligible, your coverage is automatic, and begins as soon as you are eligible.

Company-Paid Coverage

The Company pays the entire cost of the coverage for which you are eligible.

What Happens If ...

You Become Ineligible

Your coverage and benefits end on the day you are no longer eligible for coverage.

Your Employment Ends

Your coverage ends on the day your employment ends (whether or not your employment ended voluntarily).

If your employment ends while you are eligible for and receiving benefits from the Plan, your Plan benefits end on the same day your employment ends.

Plan Benefits

What the Plan Provides

The Special Benefits Plan provides benefits if you get injured, become ill or die because of, and in the course of, your employment with the Company.

If You Become Disabled

The Special Benefits Plan provides income that supplements income received from Workers' Compensation or similar benefits.

- The Special Benefits Plan pays the difference between your Pay and your Workers' Compensation or similar benefit.
  - Benefits will be payable beginning the first day of your occupational disability, as determined by the Benefit Plans Administrative Committee.
  - If there is a waiting period before Workers' Compensation or any available disability benefits start, the Special Benefits Plan will temporarily provide 100% of your Pay during the waiting period.
- Benefits can be paid for up to 6 months.
- You must cooperate with requests for information from your supervisor, the Disability and Leave Center, and Integrated Health Services (IHS) to receive benefits.
- The Plan may also provide certain medical and surgical benefits not paid under Workers' Compensation or similar laws, or other Company plans, but only for those benefits or those expenses not covered by Workers' Compensation, as well as special training, survivor benefits, and other awards (e.g., minor cash awards).

If You Die

If you die because of an occupational, accidental injury, the Special Benefits Plan provides the following:

- Subject to the approval of the Benefit Plans Administrative Committee:
  - Funeral expenses not paid by Workers' Compensation, up to $10,000;

QUALIFYING DEATHS

Your death is considered to be an occupational, accidental death eligible for benefits under this Plan if the Benefit Plans Administrative Committee determines:

- you sustained bodily injuries arising out of and in the course of employment with the Company, and
- death is caused directly and exclusively by external, violent and purely accidental means, and
- death is a result directly and independently of all other causes, and
- death occurs within 90 days after the date of the injury, and
- death is not due to:
  - infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or
  - disease or illness of any kind,
  - self-destruction or self- inflicted injury while sane or insane,
  - war or act of war in which the United States is a participant at the time of injury, or
  - participation in or in consequence of having participated in the commission of a felony.

When Benefits End

Your benefit continues for as long as you are disabled, but no longer than 6 months.

Applying for Benefits

Your supervisor or Human Resources representative will help you to apply for benefits if you become disabled. You must authorize the release of medical records and reports from your treating health care professional. You must also cooperate with the Company's designated medical staff (Integrated Health Services (IHS)), your supervisor, and the Disability and Leave Center (the Claims Administrator). Failure to cooperate may result in denial of benefits.

Management of disability cases is shared between your site and the Disability and Leave Center, the vendor who processes claims for the Special Benefits Plan and the Short-Term Disability Program. The Disability and Leave Center will assist your site in reviewing your claim, coding your absence time, and coordinating your benefits with the amount of your Workers' Compensation and any available state disability benefits. Contact the Disability and Leave Center at 1-855-267-4402.

For more information on claims procedures, contact Human Resources.

Claims Administration

Claims Appeals

Claims Other Than Those Related to Disability

If your claim for benefits (other than benefits related to disability) is denied, you will be told in writing within 90 days after your claim is received. That reply 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 and why; and
- a copy of these procedures or comparable information about the steps you need to take to resubmit your claim.

If the reply cannot be made within 90 days, you will be given a written notice explaining the reasons why. Extensions will not exceed another 90 days.

You have 60 days to appeal the denial or partial denial of your claim. If your claim for a benefit is denied, write to DuPont Human Resources—Employee Benefit Appeals, Chestnut Run Plaza, 974 Centre Road, Wilmington, DE 19805, within 60 days of the denial requesting review.

In your request, list the issues and comments you want considered. If you prefer, you may have an authorized representative send in the request on your behalf. You or your representative may, at a reasonable time and place, inspect relevant documents that may affect your claim.

Within 60 days after your request for review is received, you will receive a written response. In the case of a continued denial, you will be given the specific reasons and the Special Benefits Plan provisions on which the denial is based. If the review can't be made within 60 days, you will be notified in writing. Again, that notification will outline the reasons behind the delay.

Claims Related to Disability

If your claim for benefits related to disability is denied, you will be told in writing within 45 days after your claim is received. That reply shall be provided in a culturally and linguistically appropriate manner to the extent required under applicable law, and will include:

- the specific reasons for the denial;
- references to the specific Plan provisions on which the determination is based;
- a description of any additional material or information that is necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA 502(a) following a denial on appeal;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views you present to the Plan of health care professionals treating you and vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the determination; and

  - a disability determination regarding you made by the Social Security Administration that you presented to the Plan;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

If the reply cannot be made within 45 days, you will be given a written notice of extension. This extension will not exceed another 30 days. However, if special circumstances still prevent resolution of your claim, the Plan may take up to another 30 days after giving you notice before the end of the original 30-day extension. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You shall be afforded 45 days within which to provide the additional information, and the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date you respond to the request for additional information.

If your claim for a benefit is denied in whole or in part, you may appeal that denial within 180 days of your receipt of the denial by writing to DuPont Human Resources—Employee Benefit Appeals, Chestnut Run Plaza, 974 Centre Road, Wilmington, DE 19805.

In your appeal, list the issues and comments you want considered. If you prefer, you may have an authorized representative send in the request on your behalf. You or your representative may submit written comments, documents, records, and other information relating to your claim. You or your representative will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. The review of your appeal will take into account all comments, documents, records, and other information you submit relating to your claim.

The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the review, nor the subordinate of such individual. Where the denial of your claim is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The initial adverse determination will not be given favored consideration.

Before the Plan can issue an adverse benefit determination on appeal on a disability benefit claim, you will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date. Furthermore, before the Plan can issue an adverse benefit determination on appeal on a disability benefit claim based on a new or additional rationale, you shall be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Within 45 days after your appeal is received, you will receive a written response. However, if the review cannot be completed within 45 days, you will be notified in writing. That notification will outline the reasons behind the delay, the date by which the Plan expects to render the appeal determination, and the information needed to decide your appeal. Extensions will not exceed another 45 days. However, if the extension is needed due to your failure to submit necessary information, the time period for deciding your appeal will be tolled from the date you are sent the notice of extension until the date you respond to the request for additional information.

If your appeal is denied, the notice of denial shall be provided in a culturally and linguistically appropriate manner to the extent required under applicable law and will include:

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

You must use and exhaust the claims and appeals procedures (as described herein) before bringing a lawsuit. Failure to follow the claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding your claim.

The DuPont Benefit Plans Administrative Committee, as Plan Administrator, and the Benefit Plan Appeals Committee have full discretion and authority to interpret Plan provisions, resolve any ambiguities, and evaluate claims. The decision made by the DuPont Benefit Plans Administrative Committee or the Benefit Plan Appeals Committee is final and binding.

Addresses for Claims and Appeals

For disability claims:

The Disability and Leave Center
Sedgwick
P.O. Box 14648
Lexington, KY 40512-4648

1-855-267-4402
Fax: 1-855-800-5116

For claims other than disability claims:

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

1-833—253-7719

For appeals:

Benefit Plan Appeals Committee
974 Centre Road
Wilmington, DE 19805

1-833-253-7719

Overpayments and Other Errors

If a benefit is paid that is larger than the amount payable under the Special Benefits Plan, the Company 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.

Defined Terms

These terms are capitalized throughout this summary. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of the Plan.

"DuPont" and the "Company"

- Where we use "DuPont" in this summary, we mean DuPont de Nemours, Inc.
- Where we refer to the "Company" in this summary, we mean the DuPont affiliated organization that has adopted or participates in the Special Benefits Plan and employs you.

Integrated Health Services (IHS)

The Company's occupational medical staff or designated medical consultants.

Pay

Your Pay is defined as your regular rate of base pay computed on an annual basis without considering occasional or temporary variations from normal working hours, awards under special compensation plans or payments for relocation, severance, or other special payments.

For DuPont and any Company that adopted this Plan before January 1, 2013, Pay is the same as "Normal Annual Earnings" which includes such pay as shift differential, regular scheduled overtime, and Sunday premium pay.

Changes in Pay During Disability

If your Pay changes while you are out on disability, your Plan benefit will be adjusted accordingly.

Administrative Information

ERISA Rights

As a participant in the Special Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA entitles you to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, including work sites and union halls if applicable, all plan documents governing the Plan. These documents may include insurance contracts, collective bargaining agreements if applicable, and the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a reasonable fee for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive it within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day (or as adjusted in the future) until you receive the materials, unless the materials were not sent because of reasons beyond the 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. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You can also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Governing Law

The Plan will be construed and enforced according to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, which sets forth the minimum requirements concerning participation, vesting and other matters that an employee benefit plan must satisfy and provides rules regarding the manner in which an employee benefit plan is to be administered. ERISA also requires that an employee benefit plan prepare periodic reports and provide or make available other information to the participants in the plan. For additional information concerning your rights under ERISA, see "ERISA Rights" on page 10.

Agent for Service of Legal Process

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

Phone: 1-833-253-7719

Administrative Plan Details

Plan Name	DuPont Special Benefits Plan
Plan Number	503
Plan Sponsor	DuPont de Nemours, Inc. 974 Centre Road Wilmington, DE 19805 Phone: 1-833-253-7719
Plan Sponsor's Employer Identification Number (EIN)	81-1224539
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides disability and other benefits.
Plan Administrator	Benefit Plans Administrative Committee 974 Centre Road Wilmington, DE 19805 Phone: 1-833-253-7719
Claims Administrator	For disability claims: Sedgwick P.O. Box 14648 Lexington, KY 40512-4648 1-855-267-4402 Fax: 1-855-800-5116 For other claims: Benefit Plans Administrative Committee 974 Centre Road Wilmington, DE 19805 Phone: 1-833-253-7719
Plan Year	The plan year is January 1 through April 30.
Source of Benefits Funding	The Company pays the full cost of the Special Benefits Plan.