

Schedule of Benefits

Employer: The Dow Chemical Company

ASA: 783135

Control: 865282

Issue Date: March 15, 2017

Effective Date: March 1, 2017

Schedule: 120A

Booklet Base: 120

For: Traditional Choice - Over Age 65 Dow Retirees - Comprehensive Medical Only - MAP Plus Option 1

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Comprehensive Medical Plan

PLAN FEATURES

Calendar Year Deductible* \$250

Family Deductible* \$500

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Payment Limit excludes plan **deductible and precertification** penalties.

Individual Maximum Out of Pocket Limit: 4% of your Annual Salary to a \$4,050 maximum.

Family Payment Limit: 8% of your Annual Salary to a \$8,050 maximum.

PLAN FEATURES

Lifetime Maximum Benefit per person \$2,000,000

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, and the remaining Payment Percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

PLAN FEATURES

Preventive Care Benefits

Routine Physical Exams 100% per exam

Adults and Children.

Includes coverage for immunizations.

No Calendar Year **deductible** applies.

Maximum Exams per Calendar Year

Age 3 and over

1 exam up to a \$500 per person combined Calendar Year maximum*

* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

Well Child Exams

Includes coverage for immunizations.

100% per exam

No Calendar Year **deductible** applies.

Maximum Exams

Under age 3

first 12 months of life

7 exams

13th-24th months of life

3 exams

25th-36th months of life

3 exams

Screening & Counseling Services

100% per visit

No **copay** or Calendar Year **deductible** applies.

Office Visits

Obesity and/or Healthy Diet

Misuse of Alcohol and/or Drugs & Use of Tobacco Products

Sexually Transmitted Infections

Genetic Risk for Breast and Ovarian Cancer

Obesity and/or Healthy Diet

Maximum Visits per 12 consecutive month period
(This maximum applies only to Covered Persons ages 22 & older.)

26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Misuse of Alcohol and/or Drugs

Maximum Visits per 12 consecutive month period 5 visits*

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Use of Tobacco Products

Maximum Visits per 12 consecutive month period 8 visits*

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Sexually Transmitted Infections Benefit Maximums

Maximum Visits per 12 consecutive month period 2 visits*

***Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

Additional benefits available for Tobacco Cessation and Weight Management Programs:

Weight Management Programs:

When obesity requirements are met 100% per visit
No copay or **Calendar Year deductible** applies.

Maximum Visits per Calendar Year Up to 6 counseling sessions per Calendar Year*

**Additional sessions covered up to \$750 per Calendar Year if medically necessary*

Tobacco Cessation

includes drugs prescribed to alleviate effects of nicotine withdrawal, nicotine replacement products (i.e. Nicorette gum, Nicotine Patches) and counseling in person as well as over-the-phone 100% per service
No copay or **Calendar Year deductible** applies.

Maximum per 12 consecutive month period \$1,000

Routine Gynecological Exam

100% per exam
No Calendar Year **deductible** applies.

Maximum per Calendar Year 1 exam up to a \$500 per person combined Calendar Year maximum*

* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

PLAN FEATURES

Routine Cancer Screenings

Routine Mammography

For the 1st routine or diagnostic Mammogram (once per Calendar Year)

100% per test

No Calendar Year **deductible** applies.

Additional Mammograms

80% after Calendar Year **deductible**

Prostate Specific Antigen Test

For covered males.

100% per test

No Calendar Year **deductible** applies.

Maximum Test per Calendar Year

1 test up to a \$500 per person combined Calendar Year maximum*

* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

Routine Digital Rectal Exam

For covered males.

100% per test

No Calendar Year **deductible** applies.

Maximum exam per Calendar Year

1 exam up to a \$500 combined Calendar Year maximum*

* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipidemia.

Calendar Year maximum does not apply to immunizations.

Routine Pap Smears

100% per test

No Calendar Year **deductible** applies.

Maximum Tests per Calendar Year

1 test

<i>Fecal Occult Blood Test</i>	100% per test No Calendar Year deductible applies.
Maximum Tests per Calendar Year	1 test
<i>Sigmoidoscopy</i> Age 50 and over	100% per test No Calendar Year deductible applies.
Maximum Tests per 5 consecutive year period	1 test
<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	100% per test No Calendar Year deductible applies.
Maximum Benefit per 5 consecutive year period	1 test
<i>Colonoscopy</i> age 50 and over	100% per test No Calendar Year deductible applies.
Benefit Maximum per 10 consecutive year period	1 test
<i>Comprehensive Lactation Support and Counseling Services</i>	
Lactation Counseling Services - Facility or Office Visits.	100% per visit No Calendar Year deductible applies.
Lactation Counseling Services Maximum	Up to a \$500 combined Calendar Year maximum*
* \$500 per person, per Calendar Year maximum is a combined maximum and includes Routine Physical Exams, Vision Exam & related expenses, Routine Gynecological Exam only, Prostate Specific Antigen Test (PSA), Routine Digital Rectal Exam (DRE), Sexually Transmitted Disease (S.T.D.) Tests, Lactation Consults, Breast Cancer Genetic Risk Assessment (BCGRA)/BRCA Mutation Tests and Diet Counseling for Hypertension/Hyperlipodemia.	
Calendar Year maximum does not apply to immunizations.	

Breast Pumps & Supplies (When obtained with a Physician's Prescription)	100% per item No Calendar Year deductible applies.
Breast Pumps & Supplies Maximum	\$250 maximum
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.	

<i>Family Planning Services - Female Contraceptives</i>	
<i>Female Contraceptive Counseling Services - Office Visits.</i>	80% per visit after Calendar Year deductible

<i>Family Planning Services - Female Contraceptives</i>	
Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	80% per visit after Calendar Year deductible

<i>Family Planning - Female Voluntary Sterilization</i>	
<i>Inpatient</i>	80% per visit after Calendar Year deductible.
<i>Outpatient</i>	80% per visit after Calendar Year deductible.

<i>Family Planning Services - Other</i>	
Voluntary Sterilization for Males	
Outpatient	80% per visit after Calendar Year deductible
Voluntary Termination of Pregnancy	
Outpatient	80% per visit after Calendar Year deductible

PLAN FEATURES

<i>Physician Services</i>	
<i>Physician Office Visits</i> <i>(non-surgical)</i>	80% per visit after Calendar Year deductible

<i>Specialist Office Visits</i>	80% per visit after Calendar Year deductible
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<i>Physician Office Visit</i> <i>(Surgery)</i>	80% per visit after Calendar Year deductible
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<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible
<i>Immunizations (that are not considered Preventive Care)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prenatal Visits</i>	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	
<i>Emergency Medical Services</i>	
<i>Hospital Emergency Facility</i>	\$100 deductible per visit then the plan pays 80% No Calendar Year deductible applies.

Important Notice:
A separate **hospital** emergency room **deductible** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your deductible is waived.

Covered expenses that are applied to the emergency room **deductible** cannot be applied to any other **deductible** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** cannot be applied to the emergency room **deductible**.

PLAN FEATURES	
<i>Urgent Medical Services</i>	
<i>Urgent Medical Care (at a non-hospital free standing urgent care facility)</i>	80% per visit after Calendar Year deductible
<i>Urgent Medical Care (for other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

PLAN FEATURES	
<i>Outpatient Diagnostic and Preoperative Testing</i>	
<i>Complex Imaging Services</i>	
<i>Complex Imaging</i>	80% per procedure after Calendar Year deductible

<i>Diagnostic Laboratory Testing</i>	
<i>Diagnostic Laboratory Testing</i>	80% per procedure after Calendar Year deductible

<i>Diagnostic X-Rays (except Complex Imaging Services)</i>	
<i>Diagnostic X-Rays</i>	80% per procedure after Calendar Year deductible

PLAN FEATURES	
<i>Outpatient Surgery</i>	
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	
<i>Inpatient Facility Expenses</i>	
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Hospital Facility Expenses</i>	80% per admission after Calendar Year deductible
Room and Board (including maternity)	
Other than Room and Board	80% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	180 days*
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*Additional days of confinement subject to review for medical necessity.

PLAN FEATURES	
<i>Specialty Benefits</i>	
<i>Home Health Care (Outpatient)</i>	80% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	50 visits
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<i>Skilled Nursing Care (Outpatient)</i>	80% per visit after the Calendar Year deductible
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<i>Private Duty Nursing (Outpatient)</i>	80% per visit after the Calendar Year deductible
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Maximum Benefit per Calendar Year	\$15,000
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Hospice Benefits

<i>Hospice Care – Facility Expenses (Room & Board)</i>	100% per admission, no Calendar Year deductible applies, for the 1 st \$6,000 of combined expenses per lifetime*
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<i>Hospice Care (Other Expenses during a stay)</i>	100% per admission, no Calendar Year deductible applies, for the 1 st \$6,000 of combined expenses per lifetime*
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Maximum Benefit per lifetime	\$6,000 combined maximum*
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*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50% per Calendar Year.

<i>Hospice Outpatient Visits</i>	100% per visit no Calendar Year deductible applies, for the 1 st \$6,000 of combined expenses per lifetime*
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Maximum Benefit per lifetime	\$6,000 combined maximum
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*Combined expenses per lifetime include Inpatient Hospice, Outpatient Hospice and bereavement counseling services. Once this lifetime maximum is met, excess expenses are covered at 50% per Calendar Year.

PLAN FEATURES

Infertility Treatment

<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<i>Comprehensive Infertility Expenses</i>	50% per procedure after Calendar Year deductible
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<i>Advanced Reproductive Technology (ART) Expenses</i>	50% per procedure after Calendar Year deductible
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PLAN FEATURES***Inpatient Treatment of Mental Disorders******Mental Disorders***

Room and Board	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility</i>	80% per admission after Calendar Year deductible
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Outpatient Treatment of Mental Disorders***Outpatient Services***80% per visit after Calendar Year **deductible****PLAN FEATURES*****Inpatient Treatment of Substance Abuse******Hospital Facility Expenses***

Room and Board	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility</i>	80% per admission after Calendar Year deductible
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Outpatient Treatment of Substance Abuse***Outpatient Services***80% per visit after Calendar Year **deductible****PLAN FEATURES*****Obesity Treatment Surgical and Non Surgical******Outpatient Obesity Treatment (non surgical)***80% per visit after Calendar Year **deductible**

<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	80% per admission after Calendar Year deductible
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<i>Outpatient Morbid Obesity Surgery</i>	80% per service after Calendar Year deductible
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited
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PLAN FEATURES		IOE Facility
<i>Transplant Expenses</i>		
<i>Transplant Facility Expenses</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Transplant Physician Services</i> (including office visits)		Payable in accordance with the type of expense incurred and the place where service is provided.
PLAN FEATURES		
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>		80% after Calendar Year deductible
<i>Diabetic Education</i>		deductible
<i>Diabetic Education Calendar Year maximum</i>		\$500
<i>Durable Medical and Surgical Equipment</i>		80% per item after Calendar Year deductible
<i>Jaw Joint Disorder Non-surgical Treatment</i>		80% per visit after Calendar Year deductible
Maximum Benefit per lifetime		\$500
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Orthotic and Prosthetic Devices</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
PLAN FEATURES		
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>		Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Radiation Therapy</i>		Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES

Autism Spectrum Disorder

Autism – Physical therapy, Occupational Therapy, Speech Therapy 80% per visit after Calendar Year **deductible**

Autism - Behavioral Therapy

80% per visit after Calendar Year **deductible**

Autism - Applied Behavior Analysis

80% per visit after Calendar Year **deductible**

PLAN FEATURES

Short Term Outpatient Rehabilitation Therapies

Outpatient Physical, Occupational and Speech Therapy 80% per visit after Calendar Year **deductible**

PLAN FEATURES

Spinal Manipulation

Spinal Manipulation 50% per visit after Calendar Year **deductible**

Spinal Manipulation Benefit Maximum per Calendar Year \$500

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

All **covered expenses** accumulate toward the **deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Calendar Year Deductible

Individual

This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment Limit

The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Payment Limit**. As to the individual **Payment Limit**, each of you must meet your **Payment Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Payment Limit**. See list below.

Individual

Once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the individual **Payment Limit**, this Plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year for that person.

Family Payment Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **Payment Limit**, these expenses will also count toward a family **Payment Limit**.

To satisfy this family **Payment Limit**, for the rest of the Calendar Year, the following must happen:

The family **Payment Limit** is a cumulative **Payment Limit** for all family members. The family **Payment Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **Payment Limit** amount in a Calendar Year.

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses payable at 50%
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.