Schedule of Benefits

Employer:	**The Dow Chemical Company**
ASA:	783135
Control:	865282
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Schedule:	120B
Booklet Base:	120

For: Traditional Choice - Over Age 65 Corning 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: $1,750.

Family Payment Limit: $3,500.

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 Adults and Children. Includes coverage for immunizations.	100% per exam 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 Antigin 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.

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 Antigin 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.	

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 Antigin 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.	
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 Antigin 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.	
Routine Pap Smears	100% per test No Calendar Year **deductible** applies.
Maximum Tests per Calendar Year	1 test

Fecal Occult Blood Test	100% per test No **Calendar Year deductible** applies.
Maximum Tests per Calendar Year	1 test
Sigmoidoscopy Age 50 and over	100% per test No Calendar Year **deductible** applies.
Maximum Tests per 5 consecutive year period	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	100% per test No Calendar Year **deductible** applies.
Maximum Benefit per 5 consecutive year period	1 test
Colonoscopy age 50 and over	100% per test No Calendar Year **deductible** applies.
Benefit Maximum per 10 consecutive year period	1 test
Comprehensive Lactation Support and Counseling Services	
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 Antigin 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 *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

Family Planning Services - Female Contraceptives	
Female Contraceptive Counseling Services - Office Visits.	80% per visit after Calendar Year **deductible**

Family Planning Services - Female Contraceptives	
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**

Family Planning - Female Voluntary Sterilization	
Inpatient	80% per visit after Calendar Year **deductible.**
Outpatient	80% per visit after Calendar Year **deductible.**

Family Planning Services - Other	
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	
Physician Services	
Physician Office Visits *(non-surgical)*	80% per visit after Calendar Year **deductible**
Specialist Office Visits	80% per visit after Calendar Year **deductible**
Physician Office Visit (Surgery)	80% per visit after Calendar Year **deductible**

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

PLAN FEATURES

Emergency Medical Services

Hospital Emergency Facility	$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

Urgent Medical Services

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

PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing

Complex Imaging Services

Complex Imaging	80% per procedure after Calendar Year **deductible**

Diagnostic Laboratory Testing	
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)	
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**
PLAN FEATURES	
Outpatient Surgery	
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**
PLAN FEATURES	
Inpatient Facility Expenses	
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	180 days*
*Additional days of confinement subject to review for medical necessity.	
PLAN FEATURES	
Specialty Benefits	
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	50 visits
Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**

Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**
Maximum Benefit per Calendar Year	$15,000
Hospice Benefits	
Hospice Care – Facility Expenses (Room & Board)	100% per admission, no Calendar Year **deductible** applies, for the 1st $6,000 of combined expenses per lifetime*
Hospice Care (Other Expenses during a stay)	100% per admission, no Calendar Year **deductible** applies, for the 1st $6,000 of combined expenses per lifetime*
Maximum Benefit per lifetime	$6,000 combined maximum*
*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.	
Hospice Outpatient Visits	100% per visit no Calendar Year **deductible** applies, for the 1st $6,000 of combined expenses per lifetime*
Maximum Benefit per lifetime	$6,000 combined maximum
*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	
Basic Infertility Expenses 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.
Comprehensive Infertility Expenses	50% per procedure after Calendar Year **deductible**
Advanced Reproductive Technology (ART) Expenses	50% per procedure after Calendar Year **deductible**

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**
Inpatient Residential Treatment Facility	80% per admission after Calendar Year **deductible**
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**
Inpatient Residential Treatment Facility	80% per admission after Calendar Year **deductible**
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**
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery	80% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited

PLAN FEATURES	IOE Facility
Transplant Expenses	
Transplant Facility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	
Other Covered Health Expenses	
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**
Diabetic Education	**deductible**
Diabetic Education Calendar Year maximum	$500
Durable Medical and Surgical Equipment	80% per item after Calendar Year **deductible**
Jaw Joint Disorder Non-surgical Treatment	80% per visit after Calendar Year **deductible**
Maximum Benefit per lifetime	$500
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthotic and Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	
Outpatient Therapies	
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	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.