Insured and/or administered by:

Cigna Health and Life Insurance Company

Dow Chemical Company

Benefits at a Glance
Global Plan for Retirees and Spouse of Retirees
Policy # 02002A
Plan Start Date January 1, 2021

This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

Cigna Global Customer Service

Toll Free Telephone Number: **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	1.800.441.2668 1.302.797.3100 (collect calls accepted) 1.800.243.6998 001.302.797.3150	
Secure Website:	www.CignaEnvoy.com. Registration is Required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	PPO		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Annual Maximum	Unlimited		
Calendar Year Deductible · Per Individual · Per Family	$125 $250	$125 $250	$125 $250
Coinsurance (The percentage of covered expenses the plan pays)	85%	85%	80%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual · Per Family	$4,000 $8,000	$4,000 $8,000	$4,200 $8,400

Publication Date October 5, 2020:05:07 GMT PIF-000038304

Global Medical Plan

Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Benefit Not Covered copay payments; Benefit Not Covered pharmacy copays; Include pharmacy coinsurance payments; Benefit Not Covered Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit	85% after deductible	85% after deductible	80% after deductible
· Surgery Performed In the Physician's Office	85% after deductible	85% after deductible	80% after deductible
Preventive Care · Routine Preventive Care - all ages · Immunizations - all ages	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Inpatient Hospital Facility Services	85% after deductible	85% after deductible	80% after deductible
Inpatient Hospital Physician Visits/Consultations	85% after deductible	85% after deductible	80% after deductible
Outpatient Facility Services	85% after deductible	85% after deductible	80% after deductible
Emergency Room	85% after deductible	85% after deductible	85% after deductible
Urgent Care Facility	85% after deductible	85% after deductible	80% after deductible
Ambulance	85% after deductible	100% after deductible	100% after deductible

Publication Date October 5, 2020:05:07 GMT PIF-000038304

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Laboratory and Radiology Services (including pre-admission testing)	85% after deductible	85% after deductible	80% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)	85% after deductible	85% after deductible	80% after deductible
Short-Term Rehabilitation Calendar Year Maximum: Unlimited for all Therapies Combined *Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy **Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions	85% after deductible	85% after deductible	80% after deductible
Short-Term Rehabilitation Physical Therapy / Physiotherapy Calendar Year Maximum: Unlimited	85% after deductible	85% after deductible	80% after deductible
Chiropractic Care Calendar Year Maximum: Unlimited	85% after deductible	85% after deductible	80% after deductible
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	85% after deductible	85% after deductible	80% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	85% after deductible	85% after deductible	80% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	85% after deductible	85% after deductible	80% after deductible
· Delivery – Facility (Inpatient Hospital, Birthing Center)	85% after deductible	85% after deductible	80% after deductible
Infertility Treatments	Diagnosis of Infertility is covered under general Physician Office Visits.		
· Gift, Zift	85% after deductible	85% after deductible	80% after deductible
· Invitro	85% after deductible	85% after deductible	80% after deductible
· Artificial Insemination	85% after deductible	85% after deductible	80% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Hearing Benefit · 1 Exam Every 24 Months · Unlimited Maximum ·	Not Covered	Not Covered	Not Covered
Hearing Device / Aids · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to $1,000	85% after deductible	85% after deductible	80% after deductible
Mental Health and Substance Use Disorder · Inpatient Facility	85% after deductible	85% after deductible	80% after deductible
· Outpatient Office Visit	85% after deductible	85% after deductible	80% after deductible

Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	You pay 15% after plan deductible	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased Inside the United States Only		
Benefit Highlights	**Network Pharmacy (U.S. In-Network)**	**Non-Network Pharmacy (U.S. Out-of-Network)**
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 15% not subject to plan deductible	You pay 20% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 15% not subject to plan deductible	You pay 20% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 15% not subject to plan deductible	You pay 20% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 15% not subject to plan deductible	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 15% not subject to plan deductible	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 15% not subject to plan deductible	In-Network coverage only

Publication Date October 5, 2020:05:07 GMT PIF-000038304

Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Dispense As Written	
Prescription Drug List	Performance 3-Tier
Step Therapy	
Prior Authorization	
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Performance 3-Tier"	

Publication Date October 5, 2020:05:07 GMT PIF-000038304

Form No. 318-70149-01