Insured and/or administered by:

**Cigna Health and Life Insurance Company**

# Dow Chemical Company
# Global Plan for Retirees and Spouses of Retirees

Benefits at a Glance
Policy # 02002A
Plan Start Date January 1, 2022

**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:**<br>**Direct Telephone:**<br>**Toll Free Fax Number:**<br>**Direct Fax Number:** | 1.800.441.2668<br>1.302.797.3100 (collect calls accepted)<br>1.800.243.6998<br>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<br>P.O. Box 15050<br>Wilmington DE 19850-5050 U.S.A. | Cigna Global Health Benefits<br>300 Bellevue Parkway<br>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**<br>· Per Individual | $0 | $200 | $200 |
| · Per Family | $0 | $400 | $400 |
| **Coinsurance**<br>(The percentage of covered expenses the plan pays) | 90% | 90% | 70% |
| **Out-of-Pocket Maximum (Includes Deductible)**<br>· Per Individual | $1,500 | $1,500 | $3,000 |
| · Per Family | $3,000 | $3,000 | $6,000 |


Publication Date October 1, 2021:03:21 GMT PIF-000050124

| Global Medical Plan | |
|---|---|
| **Deductible Calculation** | Claims for a family member are covered at plan coinsurance:<br>• When that family member satisfies the Individual Deductible<br>-OR-<br>• 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:<br>• When that family member satisfies the Individual Out-of-Pocket Maximum<br>-OR-<br>• When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.<br>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.


Publication Date October 1, 2021:03:21 GMT PIF-000050124

| | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
|---|---|---|---|
| **Physician's Services** | | | |
| · Physician's Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Surgery Performed In the Physician's Office | 90% | 90% after deductible | 70% after deductible |
| **Preventive Care** | | | |
| · Routine Preventive Care - Adult | 100% | 100% not subject to deductible | 100% not subject to deductible |
| · Immunizations - Adult | 100% | 100% not subject to deductible | 100% not subject to deductible |
| · Routine Preventive Care - Child | 100% | 100% not subject to deductible | 100% not subject to deductible |
| · Immunizations - Child | 100% | 100% not subject to deductible | 100% not subject to deductible |
| **Travel Immunizations** (Immunizations as required for travel) | 100% | 100% not subject to deductible | 100% not subject to deductible |
| **Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings** | 100% | 100% not subject to deductible | 100% not subject to deductible |
| **Inpatient Hospital** | | | |
| · Inpatient Hospital - Facility Services | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Hospital Physician Visits/Consultations | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist) | 90% | 90% after deductible | 70% after deductible |
| **Outpatient Services** | | | |
| · Outpatient Facility Services | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Professional Services | 90% | 90% after deductible | 70% after deductible |
| **Emergency Room** | 90% | 90% after deductible | 70% after deductible |
| **Urgent Care Services** | 90% | 90% after deductible | 60% after deductible |
| **Ambulance** | 90% | 100% after deductible | 100% after deductible |

| Global Medical Plan | | | |
|---|---|---|---|
| | **International (Outside of the U.S.)** | **U.S. In-Network** | **U.S. Out-of-Network** |
| **Laboratory Services** | | | |
| · Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |
| · Laboratory Services at an Independent Lab facility | 90% | 90% after deductible | 70% after deductible |
| **Radiology Services** | | | |
| · Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |
| **Advanced Radiology** (i.e., MRIs, MRAs, CAT Scans, PET Scans) | | | |
| · Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Facility | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |
| **Short-Term Rehabilitation** | | | |
| · Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Hospital Facility | 90% | 90% after deductible | 70% after deductible |
| Calendar Year Maximum: | Unlimited for all Therapies Combined | | |
| The limit is not applicable to Mental Health and Substance Use Disorder conditions.<br>**Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism<br>*Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy | | | |

| Global Medical Plan | | | |
|---|---|---|---|
| | **International (Outside of the U.S.)** | **U.S. In-Network** | **U.S. Out-of-Network** |
| **Short-Term Rehabilitation - Physical Therapy / Physiotherapy**<br>· Physician Office Visit<br>· Outpatient Hospital Facility<br>Calendar Year Maximum: Unlimited for all Therapies Combined | <br>90%<br>90% | <br>90% after deductible<br>90% after deductible | <br>70% after deductible<br>70% after deductible |
| **Chiropractic Care**<br>Calendar Year Maximum: Unlimited | 90% | 90% after deductible | 70% after deductible |
| **Maternity Care Services**<br>· Initial Visit to Confirm Pregnancy<br>· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)<br>· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist<br>· Delivery – Facility<br>· Inpatient Hospital<br>· Birthing Center | <br>90%<br>90%<br>90%<br><br>90%<br>90% | <br>90% after deductible<br>90% after deductible<br>90% after deductible<br><br>90% after deductible<br>90% after deductible | <br>70% after deductible<br>70% after deductible<br>70% after deductible<br><br>70% after deductible<br>70% after deductible |


Publication Date October 1, 2021:03:21 GMT PIF-000050124

| Global Medical Plan | | | |
|---|---|---|---|
| | **International (Outside of the U.S.)** | **U.S. In-Network** | **U.S. Out-of-Network** |
| **Infertility Services** | Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services:<br>· GIFT, ZIFT, etc.<br>· In-vitro<br>· Artificial Insemination | | |
| · Physician Office Visit and Counseling | 90% | 90% after deductible | 70% after deductible |
| · Lab and Radiology Tests | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Facility | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |
| **Hearing Exam** | Not Covered | Not Covered | Not Covered |
| **Hearing Device / Aids**<br>· Limited to Dependent Children Under 24 Years<br>· 1 Per Ear Every 36 Months up to $1,000 | 90% | 90% after deductible | 70% after deductible |
| **Mental Health**<br>· Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Facility | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |
| **Substance Use Disorder**<br>· Physician Office Visit | 90% | 90% after deductible | 70% after deductible |
| · Inpatient Facility | 90% | 90% after deductible | 70% after deductible |
| · Outpatient Facility | 90% | 90% after deductible | 70% after deductible |


Publication Date October 1, 2021:03:21 GMT PIF-000050124

| Prescription Drug Benefits | | |
|---|---|---|
| **International (Outside of the U.S.)** | | |
| **Purchased outside the United States** | You pay 10% 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 10% not subject to plan deductible | You pay 40% after plan deductible |
| **Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List** | You pay 10% not subject to plan deductible | You pay 40% after plan deductible |
| **Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List** | You pay 10% not subject to plan deductible | You pay 40% 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 10% not subject to plan deductible | In-Network coverage only |
| **Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List** | You pay 10% not subject to plan deductible | In-Network coverage only |
| **Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List** | You pay 10% not subject to plan deductible | In-Network coverage only |
| **Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only** | | |
| **Dispense As Written** | If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable | |
| **Prescription Drug List** | Performance 3-Tier | |
| **Step Therapy** | Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list. | |
| **Prior Authorization** | Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list. | |
| 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 1, 2021:03:21 GMT PIF-000050124

| Global Telehealth | |
|---|---|
| **Teladoc Health International** | Available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world.<br>• Video or phone consultations with licensed doctors when medically necessary<br>• Prescriptions for common health concerns when medically necessary and permitted<br>• Treating medical conditions like fever, rash, pain and more<br>• Assistance with preparations for an upcoming consultation<br>• Discussing medication plan and potential side effects<br>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions |


Publication Date October 1, 2021:03:21 GMT PIF-000050124