




2012 Coverage Alabama

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Alaska

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Arizona

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Arkansas

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage N. California

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-464-4000 www.kaiserpermanente.org
Annual Plan Limits					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,000
Office Visits					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$5 Copay up to age 2
Chiropractic Visit and Maximum	Covered at 50%; \$500/person maximum		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Not covered
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$3 Copay, allergy serum and injection included in one Copay if same visit
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$3 Copay, allergy serum and injection included in one Copay if same visit
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% per home visit when prescribed by a Plan physician (services limited to inside the service area), limit of 3 visits per day, 100 visits per year
Maternity Care					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$5 Copay per prenatal visit (after confirmation of pregnancy) and initial post-partum visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission
Hospital Services					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency	\$100 Deductible;	\$100 Deductible; covered at	Covered at 80% after	Covered at 50% after	\$100 Copay, waived if admitted

Room	covered at 85% after Deductible	70% after Deductible	Deductible	Deductible	
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 copay per admission; no day limit
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 individual, \$7 group Copay, no visit limit
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Detox: \$250 Copay per admission, unlimited days. Rehab: Transitional Residential Recovery Service (TRRS) in a nonmedical setting: \$100 Copay per admission; no day limit
Substance Abuse: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Individual: \$15 Copay; Group: \$5 Copay, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% per item, must be in accordance with DME formulary guidelines
Prescription Coverage 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Northern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% of Plan Allowable Amount (See Note)	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 100-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 Copay formulary & nonformulary, 100-day supply (closed formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$10 Generic, \$20 brand Copay, 100-day supply




If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage

S. California

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-464-4000 www.kaiserpermanente.org
Annual Plan Limits					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,000
Office Visits					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$5 Copay up to age 2
Chiropractic Visit and Maximum	Covered at 50%; \$500/person maximum		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Not covered
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$3 Copay, allergy serum and injection included in one Copay if same visit
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$3 Copay, allergy serum and injection included in one Copay if same visit
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% per home visit when prescribed by a Plan physician (services limited to inside the service area), limit of 3 visits per day, 100 visits per year
Maternity Care					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$5 Copay per prenatal visit (after confirmation of pregnancy) and initial post-partum visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission
Hospital Services					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency	\$100 Deductible;	\$100 Deductible; covered at	Covered at 80% after	Covered at 50% after	\$100 Copay, waived if admitted



Room	covered at 85% after Deductible	70% after Deductible	Deductible	Deductible	
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 copay per admission; no day limit
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 individual, \$7 group Copay, no visit limit
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Detox: \$250 Copay per admission, unlimited days. Rehab: Transitional Residential Recovery Service (TRRS) in a nonmedical setting: \$100 Copay per admission; no day limit
Substance Abuse: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Individual: \$15 Copay; Group: \$5 Copay, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% per item, must be in accordance with DME formulary guidelines
Prescription Coverage 					
Plan Name	MAP Plus - California		Catastrophic Medical		Kaiser- Southern CA
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% of Plan Allowable Amount (See Note)	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 100-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 Copay formulary & nonformulary, 100-day supply (closed formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$10 Generic, \$20 brand Copay, 100-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Colorado

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

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2012 Coverage Connecticut

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Delaware

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-331-2102- www.mamsiunitedhealthcare.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,100
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,600
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$15 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Covered at 50%, \$500 per year
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay at first prenatal visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$75 Copay, waived if admitted
Outpatient	Covered at 85% after	Covered at 70% after	Covered at 80% after	Covered at 50% after	\$125 Copay

Surgery: Hospital	Deductible	Deductible	Deductible	Deductible	
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$25 Copay
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% after applicable Copay
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% up to a \$2,500 limit
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 31-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 formulary, \$35 nonformulary Copay, 31-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$20 Generic, \$40 formulary, \$70 nonformulary Copay, 90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Florida

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Georgia

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.







Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Hawaii

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 			
Plan Name	MAP Plus		HMSA
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-776-4672-www.hmsa.com
Annual Plan Limits 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Deductible: Individual	\$125	\$500	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$7,500
Office Visits 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	\$14 Copay
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100%
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		\$10 Copay, 12 visits per calendar year, covered at 50% of eligible charges; maximum of \$50 per calendar year
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% for outpatient services and supplies
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Maternity Care 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 90%
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 90%
Hospital Services 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	\$100 Copay per visit
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 100%
Mental Health/Substance Abuse 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%, unlimited days
	\$50 Copayment	Covered at 70% after Deductible	\$14 Copay, unlimited visits


Mental Health: Outpatient			
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%, unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	\$14 Copay, unlimited visits
Ancillary Services 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80%
Prescription Coverage 			
Plan Name	MAP Plus		HMSA
Network Type	In-Network	Out-of-Network	In Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000		
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	\$7 Copay, 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	\$30 Copay formulary, \$30 Copay plus \$35 other brand name cost share nonformulary, 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000		
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		\$11 generic, \$65 preferred brand Copay, 90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Idaho

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage

Illinois

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics			
Plan Name	MAP Plus	Catastrophic Medical	Blue Cross Blue Shield of Michigan - Illinois
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	800-892-2803 www.bcbsil.com
			800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits			
Plan Name	MAP Plus	Catastrophic Medical	Blue Cross Blue Shield of Michigan - Illinois
Network Type	In-Network	In-Network	In-Network
Deductible: Individual	\$125	\$2,500	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	\$5,000	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	\$5,000	\$1,500
			\$2,500
			\$500
			\$2,500
			\$500
			\$2,500

Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,000	\$5,000
Office Visits						
Plan Name	MAP Plus		Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP); \$30 Copay (specialist)	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	Covered at 100%	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.	Covered at 70% after Deductible; \$500/person max.	Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$30 Copay, PCP referral required; discounts available through BlueExtras	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%	Covered at 100%, 60-day maximum
Maternity Care						
Plan Name	MAP Plus		Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay, initial visit only	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released	Covered at 90%
Hospital Services						
Plan Name	MAP Plus		Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission	Covered at 90%
Emergency	\$100 Copayment;	\$100 Copayment; covered	Covered at 80% after	Covered at 50% after	\$100 Copay, waived if	\$100 Copay, waived if

Room	covered at 85% after Deductible	at 70% after Deductible	Deductible	Deductible	Deductible	admitted	admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	\$100 Copay	Covered at 90%
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	Covered at 100%	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	Covered at 100%	Covered at 90%
Mental Health/Substance Abuse							
Plan Name	MAP Plus			Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	Out-of-Network	In-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission*	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits	\$20 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission*	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits	\$20 Copay
Ancillary Services							
Plan Name	MAP Plus			Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	Out-of-Network	In-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50% after Deductible	Covered at 100%, no maximum	Covered at 90%, \$3,500 maximum per year
Prescription Coverage							
Plan Name	MAP Plus			Catastrophic Medical		Blue Cross Blue Shield of Michigan - Illinois	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	Out-of-Network	In-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.				




Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000					
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 30-day supply	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$25 formulary, \$50 nonformulary Copay, 30-day supply (open formulary)	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000					
Mail Order	80% Generic and preferred brand	80% nonpreferred brand	80% after Deductible		\$20 Generic, \$50 formulary, \$100 nonformulary Copay, 90-day supply	Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

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2012 Coverage Indiana

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage

Iowa

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Kansas

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Kentucky

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Louisiana

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-448-6262 www.humana.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$7,500
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 copay (PCP): \$35 Copay (Specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 copay (PCP): \$35 Copay (Specialist)
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay, unlimited visits
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 copay (PCP): \$35 Copay (Specialist)
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60 days maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$50 Copay (initial visit only)
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay/day, \$600 max/admission (combined mom & baby); Copay for baby if stays in hospital after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay per day, \$600 per admission maximum
Emergency Room	\$100 Copayment; covered at 85% after	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$150 Copay, waived if admitted

	Deductible				
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay per day, \$600 per admission maximum; unlimited days
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay; unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay per day; \$600 per admission maximum; unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay; unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 80%, \$1,000 annual maximum
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		Humana
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay (Level one low-cost Generics), 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$30 (Level two high-cost brand name Drugs) formulary, \$50 (Level three higher-cost generics and brand name Drugs); 25% (Level four specialty medications, with separate maximum out of pocket \$2,500 per year for Level four); nonformulary Copay, 30-day supply (closed formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$38 Level one; \$88 Level two; \$138 Level three, 90-day supply. 25% Level four specialty Drugs, 30-day supply only.

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Maine

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Maryland

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-331-2102- www.mamsiunitedhealthcare.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,100
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,600
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$15 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Covered at 50%, \$500 per year
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay at first prenatal visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$75 Copay, waived if admitted
Outpatient	Covered at 85% after	Covered at 70% after	Covered at 80% after	Covered at 50% after	\$125 Copay

Surgery: Hospital	Deductible	Deductible	Deductible	Deductible	
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$25 Copay
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% after applicable Copay
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% up to a \$2,500 limit
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 31-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 formulary, \$35 nonformulary Copay, 31-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$20 Generic, \$40 formulary, \$70 nonformulary Copay, 90-day supply


If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage

Massachusetts

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Benefit Level		
If you do not reside In Area, click here to review provisions for Out-of-Area coverage.		
Annual Plan Limits		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary
Office Visits		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount
Chiropractic Visit and Maximum	Covered at 50%; \$500/person maximum	
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible
Maternity Care		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible
Hospital Services		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible
Mental Health/Substance Abuse		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible
Substance Abuse: Outpatient	\$50 Copayment	Covered at 70% after Deductible
Ancillary Services		

Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible
Prescription Coverage 		
Plan Name	MAP Plus – Massachusetts	
Network Type	In-Network	Out-of-Network
Important Information	<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.</p>	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000	
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000	
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Michigan

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Name	MAP Plus	Catastrophic Medical	Blue Care Network of Michigan	HealthPlus of Michigan
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	800-662-6667 www.MIBCN.com	800-332-9161 www.healthplus.org
Annual Plan Limits				
Plan Name	MAP Plus	Catastrophic Medical	Blue Care Network of Michigan	HealthPlus of Michigan
Network Type	In-Network	In-Network	In-Network	In-Network
Deductible: Individual	\$125	\$2,500	None	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	\$5,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None	None
Out-of-Pocket	3% of base	\$5,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$750 per individual for	None

	annual salary	salary			inpatient admission Copay
Maximum: Individual					
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	None
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		HealthPlus of Michigan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP); \$25 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$15 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible	\$25 Copay, unlimited visits (referral required)
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50%
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 50%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		HealthPlus of Michigan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); no Copay for baby if stays in hospital after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		HealthPlus of Michigan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission

	Deductible.	Deductible.	Deductible.	Deductible.
Pharmacy Limits	<p>After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.</p> <p>Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000</p>	Deductible combined with medical.		
Pharmacy: Generic Drug	<p>In-Network Pharm: 80% after Deductible</p> <p>Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount</p>	<p>In Network Pharm: 80% after Deductible</p> <p>Out of Network Pharmacy: 50% after Deductible</p>	\$10 Copay, 34-day supply	\$10 Copay. Up to 30-day supply for 1 Copay, or 90-day supply for 2 Copays. Applies to retail pharmacies when dispensed by Rx program. (open formulary with restrictions, some medications require Prior Authorization)
Pharmacy: Brand-Name	<p>In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible</p> <p>Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount</p>	<p>In-Network Pharm: 80% after Deductible</p> <p>Out-of-Network Pharm: 50% after Deductible</p>	\$20 formulary Copay, not covered nonformulary, 34-day supply (closed formulary)	\$20 Copay. Supply up to 31-day/1 Copay or 90-day/2 Copays. Applies to eligible medications, when dispensed by retail pharmacies participating in Ask for 90 Rx program. (open formulary with restrictions, some medications require Prior Authorization)
Mail Order Limits	<p>Rx Deductible: None</p> <p>Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000</p>			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand	80% after Deductible	\$20 Generic, \$40 brand Copay, 90-day supply	\$20 Generic, \$40 formulary/nonformulary Copay, 31-90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Minnesota/Western Wisconsin

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-883-2177 www.healthpartners.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$3,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP); \$30 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	Covered at 100%
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$30 Copay, unlimited visits
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay PCP, \$30 Copay specialist
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP); \$30 Copay (specialist) (initial visit only)
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$30 Copay
Outpatient X-Ray	Covered at 85% after	Covered at 70% after Deductible	Covered at 80% after	Covered at 50% after	Covered at 100% (x-ray); covered


	Deductible		Deductible	Deductible	at 80% (CT/MRI)
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, 365 days per confinement
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay, unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, 365 days per confinement
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 80%
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		HealthPartners
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 31-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 formulary, \$40 nonformulary Copay, 31-day supply (closed formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$20 Generic, \$40 formulary, \$80 nonformulary Copay, 93-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Mississippi

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Missouri

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Montana

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Nebraska

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Nevada

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage New Hampshire

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage New Jersey

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$250
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$500
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60-day maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%


Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%, \$3,500 maximum per year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage New Mexico

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage New York

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage North Carolina

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$250
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$500
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60-day maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%

Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%, \$3,500 maximum per year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage North Dakota

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Ohio

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$250
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$500
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60-day maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%


Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%, \$3,500 maximum per year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Oklahoma

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Oregon

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Pennsylvania

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.</p>		<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>Deductible combined with medical.</p>	
Pharmacy Limits	<p>Rx Deductible \$100/\$200/\$300</p> <p>Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000</p>			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	<p>Rx Deductible: None</p> <p>Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000</p>			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Puerto Rico

The chart below summarizes some of the key features of the medical plans available in Puerto Rico. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		877-357-9777 www.ssspr.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$100
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$300
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$6,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP); \$20 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay up to age 1
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Not covered
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Not covered
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Not covered
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	25% Copay (post-hospital services)
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay per visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$50/illness or accident, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%



Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 75%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 75%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay per admission; covered subject to medical necessity (Mental Health Parity Act of 2008)
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay; covered subject to medical necessity (Mental Health Parity Act of 2008)
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$200 Copay; covered subject to medical necessity (Mental Health Parity Act of 2008)
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay; covered subject to medical necessity (Mental Health Parity Act of 2008)
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 75%, up to \$5,000 per policy year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		Triple-S PPO Plan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$5 Copay; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$10 preferred formulary/\$15 nonpreferred formulary Copay, 20% minimum; \$15 generic or brand nonformulary, 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$10 Generic/\$20 preferred formulary/\$30 nonpreferred formulary Copay, 20% minimum; \$45 generic or brand nonformulary Copay, 90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Rhode Island

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage South Carolina

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$250
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$500
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60-day maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%




Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%, \$3,500 maximum per year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage South Dakota

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.</p>		<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>Deductible combined with medical.</p>	
Pharmacy Limits	<p>Rx Deductible \$100/\$200/\$300</p> <p>Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000</p>			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	<p>Rx Deductible: None</p> <p>Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000</p>			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Tennessee

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Texas

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-CIGNA24 (244-6224) www.cigna.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	\$250
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$500
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$2,500
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$5,000
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$20 Copay (PCP), \$35 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$20 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	\$35 Copay; 20 days combined
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	The lesser of the \$20 PCP, \$35 specialist or the actual charge
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	No charge when dispensed in the physician's office
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%, 60-day maximum
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$100 Copay, waived if admitted
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%



Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$35 Copay
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 90%, \$3,500 maximum per year
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		CIGNA HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	Greater of 20% or \$7; 30-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	Greater of 30% or \$30 formulary, greater of 40% or \$50 nonformulary; 30-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		Greater of 20% or \$16 Generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 nonformulary brand

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Utah

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Vermont

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Virginia

The chart below summarizes some of the key features of the medical plans available in this state. Your eligibility for specific plans depends on your home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible


Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Washington

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible



Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Washington D.C.

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-331-2102- www.mamsiunitedhealthcare.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,100
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,600
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$15 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Covered at 50%, \$500 per year
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay at first prenatal visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$75 Copay, waived if admitted
Outpatient	Covered at 85% after	Covered at 70% after	Covered at 80% after	Covered at 50% after	\$125 Copay




Surgery: Hospital	Deductible	Deductible	Deductible	Deductible	
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$25 Copay
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% after applicable Copay
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% up to a \$2,500 limit
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 31-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 formulary, \$35 nonformulary Copay, 31-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$20 Generic, \$40 formulary, \$70 nonformulary Copay, 90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage West Virginia

The chart below summarizes some of the key features of the medical plans available living in this state. Eligibility for specific plans depends on home address.

Plan Basics					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		800-331-2102- www.mamsiunitedhealthcare.com
Annual Plan Limits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000	None
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	None
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000	\$1,100
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000	\$3,600
Office Visits					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible	\$15 Copay
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.	Covered at 50%, \$500 per year
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay (PCP), \$25 Copay (specialist)
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100%
Maternity Care					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay at first prenatal visit
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay/admission (combined mom & baby); Copay for baby if stays in hosp. after mom released
Hospital Services					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$75 Copay, waived if admitted
Outpatient	Covered at 85% after	Covered at 70% after	Covered at 80% after	Covered at 50% after	\$125 Copay


Surgery: Hospital	Deductible	Deductible	Deductible	Deductible	
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$25 Copay
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% after applicable Copay
Mental Health/Substance Abuse 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$250 Copay per admission, unlimited days
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	\$15 Copay per visit, unlimited visits
Ancillary Services 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible	Covered at 100% up to a \$2,500 limit
Prescription Coverage 					
Plan Name	MAP Plus		Catastrophic Medical		United HealthCare
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.		
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000				
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible	\$10 Copay, 31-day supply
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible	\$20 formulary, \$35 nonformulary Copay, 31-day supply (open formulary)
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000				
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible		\$20 Generic, \$40 formulary, \$70 nonformulary Copay, 90-day supply

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Wisconsin

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible




Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.		If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible. Deductible combined with medical.	
Pharmacy Limits	Rx Deductible \$100/\$200/\$300 Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	Rx Deductible: None Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.

2012 Coverage Wyoming

The chart below summarizes some of the key features of the medical plans available in this state. Eligibility for specific plans depends on home address.

Plan Basics 				
Plan Name	MAP Plus		Catastrophic Medical	
Contact Information	(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com		(800) 7DOWDOW (610) 336-1000 outside U.S. www.aetna.com	
Annual Plan Limits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,500	\$3,000
Deductible: Family	EE+1: \$250 EE+2 or more: \$375	EE+1: \$1,000 EE+2 or more: \$1,500 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.	\$5,000	\$6,000 Note: Benefits paid based on Plan Allowable Amount after annual Deductible.
Out-of-Pocket Maximum: Individual	3% of base annual salary	6% of base annual salary	\$5,000	\$6,000
Out-of-Pocket Maximum: Family	6% of base annual salary	9% of base annual salary	\$10,000	\$12,000
Office Visits 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visit	\$20 primary/\$50 specialist Copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Well Baby Care	Covered at 100% (frequency limits apply)	Covered at 100% up to the Plan Allowable Amount	Covered at 100% (frequency limits apply)	Covered at 50% after Deductible
Chiropractic Visit and Maximum	Covered at 50% after Deductible; \$500/person max.		Covered at 80% after Deductible; \$500/person max.	Covered at 50% after Deductible; \$500/person max.
Allergy Injections	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Allergy Serum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Home Health Care	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity Care 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity Office Visit	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Maternity: Inpatient Delivery	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Hospital Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Hospital	\$250 Copayment; covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Emergency Room	\$100 Copayment; covered at 85% after Deductible	\$100 Copayment; covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Surgery: Hospital	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient X-Ray	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Outpatient Lab	Covered at 100%	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible

Mental Health/Substance Abuse 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Mental Health: Outpatient	\$50 Copayment	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Inpatient	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Substance Abuse: Outpatient	\$50 copay	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Ancillary Services 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment and Maximum	Covered at 85% after Deductible	Covered at 70% after Deductible	Covered at 80% after Deductible	Covered at 50% after Deductible
Prescription Coverage 				
Plan Name	MAP Plus		Catastrophic Medical	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>After an initial retail prescription and two refills, Coinsurance will go up to 50% unless you use mail order. This does not apply to your Out-of-Pocket Maximum.</p>		<p>If a Generic Drug is available, you are responsible for the Generic Copay plus the difference in cost between the brand-name and Generic Drug, plus any Deductible.</p> <p>Deductible combined with medical.</p>	
Pharmacy Limits	<p>Rx Deductible \$100/\$200/\$300</p> <p>Rx Out-of-Pocket Max. \$1,000/ \$2,000/\$3,000</p>			
Pharmacy: Generic Drug	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 80% (after Deductible) of Plan Allowable Amount	In Network Pharmacy: 80% after Deductible	Out of Network Pharmacy: 50% after Deductible
Pharmacy: Brand-Name	In-Network Pharm: 80% preferred brand/70% nonpreferred brand after Deductible	Out-of-Network Pharm: 80% preferred brand/70% nonpreferred brand (after Deductible) of Plan Allowable Amount	In-Network Pharm: 80% after Deductible	Out-of-Network Pharm: 50% after Deductible
Mail Order Limits	<p>Rx Deductible: None</p> <p>Rx Out-of-Pocket Max: \$1,000/\$2,000/\$3,000</p>			
Mail Order	80% Generic and preferred brand, 70% nonpreferred brand		80% after Deductible	

If there are discrepancies between this information and the legal documents of any of the Plans, the legal documents will govern. The Dow Chemical Company reserves the right to change, amend, modify or terminate any of the Plans at any time at its sole discretion.