

2020 Dow Medical Premiums and Coverage Summary - Michigan

Plan Basics			
Plan Name	MAP Plus - Option 1 Low Deductible		Blue Care Network of Michigan
Contact Information	888-488-4488 610-336-1000 outside U.S. www.aetna.com		888-488-4488 610-336-1000 outside U.S. www.aetna.com 800-662-6667 www.bcbsm.com

Plan Costs			
Plan Name	MAP Plus - Option 1 Low Deductible		Blue Care Network of Michigan
Employee Only			
Full Time (Non-tobacco / Tobacco user)	\$129 / \$179	\$30 / \$80	\$100 / \$150
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$170 / \$220	\$75 / \$125	\$137 / \$187
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$341 / \$391	\$151 / \$201	\$274 / \$324
Employee + Spouse/Domestic Partner			
Full Time (Non-tobacco / Tobacco user)	\$296 / \$346	\$69 / \$119	\$230 / \$280
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$341 / \$391	\$151 / \$201	\$274 / \$324
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$683 / \$733	\$302 / \$352	\$549 / \$599
Employee + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	\$254 / \$304	\$59 / \$109	\$197 / \$247
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$293 / \$343	\$129 / \$179	\$236 / \$286
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$587 / \$637	\$259 / \$309	\$472 / \$522
Employee + Spouse/DP + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	\$436 / \$486	\$101 / \$151	\$338 / \$388
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$504 / \$554	\$222 / \$272	\$405 / \$455
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$1,008 / \$1,058	\$445 / \$495	\$810 / \$860

Note: If you are paid bi-weekly and would like to calculate your per-pay premium, multiply the monthly premium amount by 12 and divide by 26 (the number of pay periods for 2020).

Annual Plan Limits					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible: Individual	\$125	\$500	\$2,000	\$4,000	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.	\$4,000 with max of \$2,800 for one person	\$8,000	None
Out-of-Pocket Maximum: Individual (includes deductible)	4% of base salary up to a maximum of \$8,150	8% of base salary	\$4,000	\$8,000	\$6,450
Out-of-Pocket Maximum: Family (includes deductible)	8% of base salary up to a maximum of \$16,300	12% of base salary	\$8,000	\$16,000	\$12,900

Office Visits					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network 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 60% after deductible	\$15 copay (PCP); \$30 copay (specialist)
Dow Family Health Center Physician Visit	\$10 copay	N/A	Subject to deductible and coinsurance	N/A	\$10 copay
Chiropractic Visit	Covered at 85% after deductible; 30 visit max	Covered at 70% after deductible; 30 visit max	Covered at 80% after deductible; 30 visit max	Covered at 60% after deductible; 30 visit max	\$30 copay
Well Baby Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Routine Physical Exam	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Routine Gynecological Exam	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Routine Mammography	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Telemedicine	\$20 copay	N/A	\$40 consult fee until deductible is met, then subject to coinsurance	N/A	N/A

Maternity Care					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Pre/Post-Natal Maternity office visit	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	\$0 copay routine pre-natal visit; \$15 copay post-natal visit
Maternity: Inpatient Delivery	\$250 copay, covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$250 copay/admission

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Hospital Services					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Inpatient Hospital	\$250 copay, covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$250 copay
Emergency Room	\$100 copay, covered at 85% after deductible	\$100 copay, covered at 85% after deductible	Covered at 80% after deductible	Covered at 80% after deductible	\$100 copay, waived if admitted, however, inpatient copay will apply
Outpatient Surgery: Hospital	Covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$100 copay
Outpatient X-Ray	Covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 100%
Outpatient Lab	Covered at 100%	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 100%
Urgent Care	\$20 copay after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$15 copay

Mental Health / Substance Abuse					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Mental Health: Inpatient	\$250 copay; covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 100% when authorized; unlimited days
Mental Health: Outpatient	\$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$15 copay when authorized; unlimited visits
Substance Abuse: Inpatient	\$250 copay; covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 100% when authorized; unlimited days
Substance Abuse: Outpatient	\$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$15 copay when authorized; unlimited visits

Ancillary Services					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
	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 60% after deductible	Covered at 80%

Prescription Coverage					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		Blue Care Network of Michigan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Important Information	<p>If a generic drug is available, you are responsible for the generic coinsurance 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>Certain drugs require pre-certification and/or step therapy. Specialty drug cost sharing differs.</p>		<p>Certain preventive medications are covered with no deductible (in-network 80% and out-of-network 60%).</p> <p>If a generic drug is available, you are responsible for the generic coinsurance plus the difference in cost between the brand-name and generic drug, plus any deductible.</p> <p>Certain drugs require pre-certification and/or step therapy.</p>		
Pharmacy Limits	<p>Rx deductible: \$100/\$200/\$300</p> <p>Rx Out-of-Pocket Max combined with medical</p>		<p>Deductible and Out-of-Pocket Maximum combined with medical</p>		
Pharmacy: Generic Drug	Covered at 80% after deductible	Covered at 80% up to the Plan Allowable Amount after deductible	Covered at 80% after deductible	Covered at 60% after deductible	\$10 copay, 30-day supply
Pharmacy: Brand Name	Covered at 80% preferred brand/70% non-preferred brand after deductible	Covered at 80% preferred brand/70% non-preferred brand (after deductible) of Plan Allowable Amount	Covered at 80% after deductible	Covered at 60% after deductible, no coverage for Specialty Rx if non-network pharmacy is used	\$20 formulary copay, non-formulary not covered, 30-day supply (closed formulary)
Dow Family Health Center Pharmacy	\$2 copay per script. For maintenance medication, available for up to 3 fills. After 3 fills, must switch to mail order pharmacy. For non-maintenance Rx, \$2 copay per script, subject to certain Rx	N/A	Before deductible, scheduled cost of drug. After deductible, \$2 copay per script	N/A	\$2 for covered and carried pharmacy drugs
Mail Order Limits	<p>Rx deductible: None</p> <p>Rx Out-of-Pocket Max combined with medical</p>		<p>Deductible and Out-of-Pocket Maximum combined with medical</p>		
Mail Order	<p>Covered at 80% generic and preferred brand, 70% non-preferred brand</p>		<p>Covered at 80% after deductible</p>		\$20 generic, \$40 formulary, non-formulary not covered, 90 day supply

The foregoing descriptions provide only general information about Dow's applicable compensation and benefits programs. You should refer to the plan document and summary plan description of the applicable plan for a more complete description of the plan's terms. If there is any conflict between the information provided above and the plan document or summary plan description for the applicable plan, the plan document or summary plan description will govern. This summary in no way alters any employee's status as an "at will" employee of Dow and does not create any third-party beneficiary rights, or any right to employment or continued employment with Dow or any of its affiliates. Dow reserves the right to amend or terminate the terms of the foregoing plans in accordance with their terms.