2020 Dow Medical Premiums and Coverage Summary - Puerto Rico

Plan Basics

Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible	TRIPLE-S, Inc
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	1-787-774-6060 www.ssspr.com

Plan Costs

Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible	TRIPLE-S, Inc
Employee Only			
Full Time (Non-tobacco / Tobacco user)	$129 / $179	$30 / $80	$68 / $118
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	$170 / $220	$75 / $125	$95 / $145
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	$341 / $391	$151 / $201	$191 / $241
Employee + Spouse/Domestic Partner			
Full Time (Non-tobacco / Tobacco user)	$296 / $346	$69 / $119	$156 / $206
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	$341 / $391	$151 / $201	$191 / $241
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	$683 / $733	$302 / $352	$382 / $432
Employee + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	$254 / $304	$59 / $109	$134 / $184
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	$293 / $343	$129 / $179	$164 / $214
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	$587 / $637	$259 / $309	$328 / $378
Employee + Spouse/DP + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	$436 / $486	$101 / $151	$230 / $280
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	$504 / $554	$222 / $272	$281 / $331
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	$1,008 / $1,058	$445 / $495	$563 / $613

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		TRIPLE-S, Inc
Network Type	**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	$2,000 for major medical; $6,350 total
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	$6,000 for major medical; $12,700 total

Office Visits

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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); $20 copay (specialist)
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	$15 copay through Triple-S Natural Program
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%	25% coinsurance; or covered at 100% if preventive
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		TRIPLE-S, Inc
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%	$20 copay per 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	$200 copay/admission (combined mom & baby)

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Hospital Services

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
Network Type	**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	$200 copay per admission
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	$50/illness or accident (waived if admitted); No charge if recommended by Teleconsulta
Outpatient Surgery: Hospital	Covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% 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 60% after deductible	25% coinsurance
Outpatient Lab	Covered at 100%	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	25% coinsurance
Urgent Care	$20 copay after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	N/A

Mental Health / Substance Abuse

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
Network Type	**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	$200 copay per admission, $50 copay per partial admission
Mental Health: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$5 group, $20 individual
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	$200 copay per admission, $50 copay per partial admission
Substance Abuse: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$5 group, $20 individual

Ancillary Services

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 60% after deductible	25% coinsurance

Prescription Coverage

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 coinsurance 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. Certain drugs require pre-certification and/or step therapy. Specialty drug cost sharing differs.		Certain preventive medications are covered with no deductible (in-network 80% and out-of-network 60%). 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. Certain drugs require pre-certification and/or step therapy.		
Pharmacy Limits	Rx deductible: $100/$200/$300 Rx Out-of-Pocket Max combined with medical		Deductible and Out-of-Pocket Maximum combined with medical		
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	$5 copay: Level 1 Preferred Generics & Level 2 Non-Preferred Generics; 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	$10 copay: Level 3 Preferred Brand; $15 copay: Level 4 Non-Preferred Brand; 20% coinsurance, $15 min copay: Level 5 Preferred Specialty & Level 6 Non-Preferred Specialty; 30 day supply
Mail Order Limits	Rx deductible: None Rx Out-of-Pocket Max combined with medical		Deductible and Out-of-Pocket Maximum combined with medical		
Mail Order	Covered at 80% generic and preferred brand, 70% non-preferred brand		Covered at 80% after deductible		$10 copay: Level 1 Preferred Generic & Level 2 Non-Preferred Generic; $20 copay: Level 3 Preferred Brand; $45 copay: Level 4 Non-Preferred Brand; 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.