2020 Dow COBRA Monthly Medical Cost and Coverage Summary - Illinois

Plan Basics			
Plan Name	**MAP Plus - Option 1 Low Deductible**	**MAP Plus - Option 2 High Deductible**	**CIGNA HMO National**
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-CIGNA24 (244-6224) www.cigna.com

Plan Costs			
Plan Name	**MAP Plus - Option 1 Low Deductible**	**MAP Plus - Option 2 High Deductible**	**CIGNA HMO National**
Employee Only			
Subsidized Rates[1]	$129.00	$30.00	$122.00
COBRA Rates	$697.09	$308.12	$689.83
Employee + Spouse/Domestic Partner			
Subsidized Rates[1]	$296.00	$69.00	$280.00
COBRA Rates	$1,394.17	$616.25	$1,379.65
Employee + Child(ren)			
Subsidized Rates[1]	$254.00	$59.00	$241.00
COBRA Rates	$1,198.99	$529.97	$1,186.52
Employee + Spouse/DP + Child(ren)			
Subsidized Rates[1]	$436.00	$101.00	$412.00
COBRA Rates	$2,056.40	$908.97	$2,034.98

1) 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**		**CIGNA HMO National**
Network Type	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Deductible: Individual	$125	$500	$2,000	$4,000	$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.	$4,000 with max of $2,800 for one person	$8,000	$500
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	$3,000
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

Office Visits					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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	$20 copay (PCP), $35 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	$35 copay; 60 days combined
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	$20 copay

Maternity Care					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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 for initial visit; remaining pre/post-natal visits covered at 90% after deductible
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	Covered at 90% after deductible

2020 Dow COBRA Monthly Medical Cost and Coverage Summary - Illinois

Hospital Services					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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	Covered at 90% after deductible
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
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 90% after deductible
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% in doctor's office or independent lab; covered at 90% after deductible at outpatient facility
Outpatient Lab	Covered at 100%	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 100% in doctor's office or independent lab; covered at 90% after deductible at outpatient facility
Urgent Care	$20 copay after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$50 copay

Mental Health / Substance Abuse					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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	Covered at 90% after deductible
Mental Health: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$20 copay for office visit, 10% coinsurance for other services
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 90% after deductible
Substance Abuse: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$20 copay for office visit, 10% coinsurance for other services

Ancillary Services					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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	Covered at 100%

Prescription Coverage					
Plan Name	**MAP Plus - Option 1 Low Deductible**		**MAP Plus - Option 2 High Deductible**		**CIGNA HMO National**
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 out-of-pocket is combined with medical
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	Greater of 20% or $7; $100 copay maximum per script; 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	Greater of 30% or $30 formulary, greater of 40% or $50 non-formulary; $100 copay maximum per script; 30-day supply (open formulary)
Mail Order Limits	Rx deductible: None Rx Out-of-Pocket Max combined with medical		Deductible and Out-of-Pocket Maximum combined with medical		90-day supply limit on all mail order drugs
Mail Order	Covered at 80% generic and preferred brand, 70% non-preferred brand		Covered at 80% after deductible		Greater of 20% or $16 generic, greater of 30% or $85 formulary brand, greater of 40% or $145 non-formulary brand; $200 copay maximum per script

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.