

2020 Dow COBRA Monthly Medical Cost and Coverage Summary - Louisiana

| Plan Basics | | | |
|---------------------|--|--|--------------------------------|
| Plan Name | MAP Plus - Option 1 Low Deductible | MAP Plus - Option 2 High Deductible | Humana Health Plan of LA |
| 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 | 800-448-6262 www.humana.com |

| Plan Costs | | | |
|---|------------------------------------|-------------------------------------|--------------------------|
| Plan Name | MAP Plus - Option 1 Low Deductible | MAP Plus - Option 2 High Deductible | Humana Health Plan of LA |
| Employee Only | | | |
| Subsidized Rates ¹ | \$129.00 | \$30.00 | \$103.00 |
| COBRA Rates | \$697.09 | \$308.12 | \$621.96 |
| Employee + Spouse/Domestic Partner | | | |
| Subsidized Rates ¹ | \$296.00 | \$69.00 | \$236.00 |
| COBRA Rates | \$1,394.17 | \$616.25 | \$1,243.91 |
| Employee + Child(ren) | | | |
| Subsidized Rates ¹ | \$254.00 | \$59.00 | \$203.00 |
| COBRA Rates | \$1,198.99 | \$529.97 | \$1,069.77 |
| Employee + Spouse/DP + Child(ren) | | | |
| Subsidized Rates ¹ | \$436.00 | \$101.00 | \$348.00 |
| COBRA Rates | \$2,056.40 | \$908.97 | \$1,834.77 |

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 | | Humana Health Plan of LA |
| | 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 | \$6,350 total (\$2,500 medical only) |
| 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 | \$12,700 total (\$7,500 medical only) |

| Office Visits | | | | | |
|----------------------------|---|---|---|---|---|
| Plan Name | MAP Plus - Option 1 Low Deductible | | MAP Plus - Option 2 High Deductible | | Humana Health Plan of LA |
| | 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 | \$20 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 | \$20 copay |

| Maternity Care | | | | | |
|---------------------------------------|--|---------------------------------|-------------------------------------|---------------------------------|--|
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| | 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% | \$50 copay (initial visit only) |
| 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/day, \$600 max/admission (combined mom & baby); copay for baby if stays in hospital after mom released |

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| Hospital Services | | | | | |
|------------------------------|--|--|-------------------------------------|---------------------------------|--|
| Plan Name | MAP Plus - Option 1 Low Deductible | | MAP Plus - Option 2 High Deductible | | Humana Health Plan of LA |
| 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 day, \$600 per admission maximum |
| 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 | \$150 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 | \$200 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 | \$35 copay |

| Mental Health / Substance Abuse | | | | | |
|---------------------------------|--|---------------------------------|-------------------------------------|---------------------------------|--|
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| 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 day, \$600 per admission maximum; unlimited days |
| Mental Health: Outpatient | \$20 copay | Covered at 70% after deductible | Covered at 80% after deductible | Covered at 60% after deductible | \$20 copay |
| 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 day; \$600 per admission maximum; unlimited days |
| Substance Abuse: Outpatient | \$20 copay | Covered at 70% after deductible | Covered at 80% after deductible | Covered at 60% after deductible | \$20 copay |

| Ancillary Services | | | | | |
|---------------------------------------|------------------------------------|---------------------------------|-------------------------------------|---------------------------------|--------------------------|
| Plan Name | MAP Plus - Option 1 Low Deductible | | MAP Plus - Option 2 High Deductible | | Humana Health Plan of LA |
| 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 80% |

| Prescription Coverage | | | | | |
|------------------------|--|--|--|---|--|
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| Network Type | 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> | | <p>Out-of-pocket 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 (level one low-cost 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 | \$30 (level two high-cost generic and brand name drugs), \$50 (level three higher-cost brand name drugs); 25% (level four specialty medications), 30-day supply (closed formulary) |
| 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> | | <p>\$25 level one; \$75 level two; \$125 level three, 90-day supply</p> |

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.