2021 Dow Medical Premiums and Coverage Summary - Pennsylvania

Plan Basics					
Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible			
	888-488-4488	888-488-4488			
Contact Information	610-336-1000 outside U.S.	610-336-1000 outside U.S.			
	www.aetna.com	www.aetna.com			

Plan Costs			
Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible	
Employee Only			
Full Time (Non-tobacco / Tobacco user)	\$138 / \$188	\$30 / \$80	
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$184 / \$234	\$82 / \$132	
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$368 / \$418	\$165 / \$215	
Employee + Spouse/Domestic Partner			
Full Time (Non-tobacco / Tobacco user)	\$317 / \$367	\$69 / \$119	
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$368 / \$418	\$165 / \$215	
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$737 / \$787	\$330 / \$380	
Employee + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	\$272 / \$322	\$59 / \$109	
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$317 / \$367	\$142 / \$192	
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$634 / \$684	\$284 / \$334	
Employee + Spouse/DP + Child(ren)			
Full Time (Non-tobacco / Tobacco user)	\$466 / \$516	\$101 / \$151	
Less Than Full Time: 30 - 39 hours/week (Non-tobacco / Tobacco user)	\$544 / \$594	\$243 / \$293	
Less Than Full Time: 20 - 29 hours/week (Non-tobacco / Tobacco user)	\$1,088 / \$1,138	\$487 / \$537	

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 2021).

Annual Plan Limits				
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible	
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible: Individual	\$125	\$500	\$2,000	\$4,000
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.	\$4,000 with max of \$2,800 for one person	\$8,000
Out-of-Pocket Maximum: Individual (includes deductible)	4% of base salary up to a maximum of \$8,550	8% of base salary	\$4,000	\$8,000
Out-of-Pocket Maximum: Family (includes deductible)	8% of base salary up to a maximum of \$17,100	12% of base salary	\$8,000	\$16,000

Office Visits					
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		
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 60% after deductible	
Dow Family Health Center Physician Visit	\$10 copay; applicable in geographies with a Dow Family Health Center	N/A	Subject to deductible and coinsurance; applicable in geographies with a Dow Family Health Center	N/A	
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	
Well Baby Care	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%	
Routine Gynecological Exam	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%	
Telemedicine	\$20 copay	N/A	\$40 consult fee until deductible is met, then	N/A	

Maternity Care				
Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option	n 2 High Deductible
Network Type	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre/Post-Natal Maternity office visit	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
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

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Hospital Services		<u></u>		
Plan Name	MAP Plus - Option 1 Low Deductible MAP Plus - Option 2 High Deduc			2 High Deductible
Network Type	In-Network	Out-of-Network	In-Network	Out-of-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
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
Outpatient Surgery: Hospital	Covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% 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
Outpatient Lab	Covered at 100%	Covered at 70% after	Covered at 80% after	Covered at 60% after
Urgent Care	\$20 copay after deductible	deductible Covered at 70% after deductible	deductible Covered at 80% after deductible	deductible Covered at 60% after deductible
Mental Health / Substance Abuse				
Plan Name	MAP Plus - Option	1 1 Low Deductible	MAP Plus - Option	2 High Deductible
Network Type	In-Network	Out-of-Network	In-Network	Out-of-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
Mental Health: Outpatient	\$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
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
Substance Abuse: Outpatient	\$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Ancillary Services				
Plan Name	MAP Plus - Ontion	1 Low Deductible	MAP Plus - Option	2 High Deductible
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	Covered at 60% after deductible
	deductible	deductible	deductible	deductible
Prescription Coverage			<u> </u>	
Plan Name	MAP Plus - Option	1 Low Deductible	MAP Plus - Option 2 High Deductible	
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 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	
	will go up to 50% unless you us apply to your Out-of-Pocket Ma Certain drugs require pre-certi Specialty drug cost sharing diff	se mail order. This does not aximum. fication and/or step therapy. fers.	brand-name and generic drug, Certain drugs require pre-certi	plus any deductible. fication and/or step therapy
Pharmacy Limits	will go up to 50% unless you us apply to your Out-of-Pocket Mac Certain drugs require pre-certi Specialty drug cost sharing diff Rx deductible: \$100/\$200/\$300	se mail order. This does not aximum. fication and/or step therapy. fers.	brand-name and generic drug,	plus any deductible. fication and/or step therapy
Pharmacy: Generic Drug	will go up to 50% unless you us apply to your Out-of-Pocket Ma Certain drugs require pre-certi Specialty drug cost sharing diff	se mail order. This does not aximum. fication and/or step therapy. fers. o ed with medical Covered at 80% up to the Plan Allowable Amount after	brand-name and generic drug, Certain drugs require pre-certi Deductible and Out-of-Pocket	plus any deductible. fication and/or step therapy
Pharmacy: Generic Drug	will go up to 50% unless you us apply to your Out-of-Pocket Mac Certain drugs require pre-certi Specialty drug cost sharing diff Rx deductible: \$100/\$200/\$300/Rx Out-of-Pocket Max combination Covered at 80% after	se mail order. This does not aximum. fication and/or step therapy. fers. O ed with medical Covered at 80% up to the	brand-name and generic drug, Certain drugs require pre-certi Deductible and Out-of-Pocket medical Covered at 80% after	plus any deductible. fication and/or step therapy Maximum combined with Covered at 60% after deductible Covered at 60% after deductible, no coverage for
Pharmacy: Generic Drug Pharmacy: Brand Name Dow Family Health Center Pharmacy	will go up to 50% unless you us apply to your Out-of-Pocket Mic Certain drugs require pre-certif Specialty drug cost sharing differ Rx deductible: \$100/\$200/\$30(Rx Out-of-Pocket Max combine Covered at 80% after deductible Covered at 80% preferred brand/70% non-preferred brand/70% non-preferred brand after deductible \$2 copay per script, subject to certain Rx; applicable in geographies with a Dow Family Health Center	se mail order. This does not aximum. fication and/or step therapy. fers. O ed with medical Covered at 80% up to the Plan Allowable Amount after deductible Covered at 80% preferred brand/70% non-preferred brand (after deductible) of Plan Allowable Amount	brand-name and generic drug, Certain drugs require pre-certi Deductible and Out-of-Pocket medical Covered at 80% after deductible Covered at 80% after deductible Before deductible, scheduled cost of drug. After deductible, \$2 copay per script; applicable in geographies with a Dow Family Health Center	plus any deductible. fication and/or step therapy Maximum combined with Covered at 60% after deductible Covered at 60% after deductible, no coverage fo Specialty Rx if non-networl pharmacy is used N/A
Pharmacy: Generic Drug Pharmacy: Brand Name	will go up to 50% unless you us apply to your Out-of-Pocket Mac Certain drugs require pre-certif Specialty drug cost sharing differ Rx deductible: \$100/\$200/\$300 Rx Out-of-Pocket Max combine Covered at 80% after deductible Covered at 80% preferred brand/70% non-preferred brand/70% non-preferred brand after deductible \$2 copay per script, subject to certain Rx; applicable in geographies with a Dow Family Health Center Rx deductible: None	se mail order. This does not aximum. fication and/or step therapy. fers. oed with medical Covered at 80% up to the Plan Allowable Amount after deductible Covered at 80% preferred brand/70% non-preferred brand (after deductible) of Plan Allowable Amount N/A	brand-name and generic drug, Certain drugs require pre-certi Deductible and Out-of-Pocket medical Covered at 80% after deductible Covered at 80% after deductible Before deductible, scheduled cost of drug. After deductible, \$2 copay per script; applicable in geographies with	plus any deductible. fication and/or step therapy Maximum combined with Covered at 60% after deductible Covered at 60% after deductible, no coverage fo Specialty Rx if non-networl pharmacy is used N/A
Pharmacy: Generic Drug Pharmacy: Brand Name Dow Family Health Center Pharmacy	will go up to 50% unless you us apply to your Out-of-Pocket Mic Certain drugs require pre-certif Specialty drug cost sharing differ Rx deductible: \$100/\$200/\$30(Rx Out-of-Pocket Max combine Covered at 80% after deductible Covered at 80% preferred brand/70% non-preferred brand/70% non-preferred brand after deductible \$2 copay per script, subject to certain Rx; applicable in geographies with a Dow Family Health Center	se mail order. This does not aximum. fication and/or step therapy. fers. O ed with medical Covered at 80% up to the Plan Allowable Amount after deductible Covered at 80% preferred brand/70% non-preferred brand (after deductible) of Plan Allowable Amount N/A	brand-name and generic drug, Certain drugs require pre-certi Deductible and Out-of-Pocket medical Covered at 80% after deductible Covered at 80% after deductible Before deductible, scheduled cost of drug. After deductible, \$2 copay per script, applicable in geographies with a Dow Family Health Center Deductible and Out-of-Pocket	plus any deductible. fication and/or step therapy Maximum combined with Covered at 60% after deductible Covered at 60% after deductible, no coverage fo Specialty Rx if non-networl pharmacy is used N/A Maximum combined with

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.