

2021 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	\$138.00	\$30.00	\$103.00
COBRA Rates	\$752.43	\$337.17	\$679.16
Employee + Spouse/Domestic Partner			
Subsidized Rates ¹	\$317.00	\$69.00	\$236.00
COBRA Rates	\$1,504.87	\$674.35	\$1,358.30
Employee + Child(ren)			
Subsidized Rates ¹	\$272.00	\$59.00	\$203.00
COBRA Rates	\$1,294.19	\$579.94	\$1,168.14
Employee + Spouse/DP + Child(ren)			
Subsidized Rates ¹	\$466.00	\$101.00	\$348.00
COBRA Rates	\$2,219.67	\$994.66	\$2,003.49

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 2021).

Annual Plan Limits					
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
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 \$8,550	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 \$17,100	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
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	\$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					
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
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					
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
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					
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
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.