2021 Dow Monthly Medical COBRA Cost and Coverage Summary - Pennsylvania

Plan Basics		
Plan Name	**MAP Plus - Option 1 Low Deductible**	**MAP Plus - Option 2 High Deductible**
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

Plan Costs		
Plan Name	**MAP Plus - Option 1 Low Deductible**	**MAP Plus - Option 2 High Deductible**
Employee Only		
Subsidized Rates[1]	$138.00	$30.00
COBRA Rates	$752.43	$337.17
Employee + Spouse/Domestic Partner		
Subsidized Rates[1]	$317.00	$69.00
COBRA Rates	$1,504.87	$674.35
Employee + Child(ren)		
Subsidized Rates[1]	$272.00	$59.00
COBRA Rates	$1,294.19	$579.94
Employee + Spouse/DP + Child(ren)		
Subsidized Rates[1]	$466.00	$101.00
COBRA Rates	$2,219.67	$994.66

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**	
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	N/A	Subject to deductible and coinsurance; applicable in	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 subject to coinsurance	N/A

Maternity Care				
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**
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				
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**
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 deductible	Covered at 80% after deductible	Covered at 60% after deductible
Urgent Care	$20 copay after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible

Mental Health / Substance Abuse				
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**
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 - Option 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 deductible	Covered at 60% after deductible

Prescription Coverage				
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.	
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
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
Dow Family Health Center Pharmacy	$2 copay per script, subject to certain Rx; applicable in geographies with a Dow Family Health Center	N/A	Before deductible, scheduled cost of drug. After deductible, $2 copay per script; applicable in geographies with a Dow Family Health Center	N/A
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	