2021 Dow Monthly Medical COBRA Cost and Coverage Summary - Puerto Rico

Plan Basics

Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible	TRIPLE-S, Inc
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	1-787-774-6060 www.ssspr.com

Plan Costs

Plan Name	MAP Plus - Option 1 Low Deductible	MAP Plus - Option 2 High Deductible	TRIPLE-S, Inc
Employee Only			
Subsidized Rates[1]	$138.00	$30.00	$68.00
COBRA Rates	$752.43	$337.17	$388.52
Employee + Spouse/Domestic Partner			
Subsidized Rates[1]	$317.00	$69.00	$156.00
COBRA Rates	$1,504.87	$674.35	$808.04
Employee + Child(ren)			
Subsidized Rates[1]	$272.00	$59.00	$134.00
COBRA Rates	$1,294.19	$579.94	$695.64
Employee + Spouse/DP + Child(ren)			
Subsidized Rates[1]	$466.00	$101.00	$230.00
COBRA Rates	$2,219.67	$994.66	$1,192.53

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		TRIPLE-S, Inc
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	$2,000 for major medical; $6,350 total
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	$6,000 for major medical; $12,700 total

Office Visits

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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	$15 copay (PCP); $20 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	$15 copay through Triple-S Natural Program
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%	25% coinsurance; or covered at 100% if preventive
Telemedicine	$20 copay	N/A	$40 consult fee until deductible is met, then subject to coinsurance	N/A	N/A

Maternity Care

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 per visit
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/admission (combined mom & baby)

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Hospital Services

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 admission
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	$50/illness or accident (waived if admitted); No charge if recommended by Teleconsulta
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 100%
Outpatient X-Ray	Covered at 85% after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	25% coinsurance
Outpatient Lab	Covered at 100%	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	25% coinsurance
Urgent Care	$20 copay after deductible	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	N/A

Mental Health / Substance Abuse

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 admission, $50 copay per partial admission
Mental Health: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$5 group, $20 individual
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 admission, $50 copay per partial admission
Substance Abuse: Outpatient	$20 copay	Covered at 70% after deductible	Covered at 80% after deductible	Covered at 60% after deductible	$5 group, $20 individual

Ancillary Services

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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	25% coinsurance

Prescription Coverage

Plan Name	MAP Plus - Option 1 Low Deductible		MAP Plus - Option 2 High Deductible		TRIPLE-S, Inc
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 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	$5 copay: Level 1 Preferred Generics & Level 2 Non-Preferred 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	$10 copay: Level 3 Preferred Brand, $15 copay: Level 4 Non-Preferred Brand, 20% coinsurance, $15 min copay: Level 5 Preferred Specialty & Level 6 Non-Preferred Specialty; 30 day supply
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		$10 copay: Level 1 Preferred Generic & Level 2 Non-Preferred Generic, $20 copay: Level 3 Preferred Brand, $45 copay: Level 4 Non-Preferred Brand; 90 day supply