

**2021 Dow Monthly Medical COBRA Cost and Coverage Summary - Texas**

| <b>Plan Basics</b>  |  |  |   |
|---------------------|--|--|---|
| Plan Name           | MAP Plus - Option 1 Low Deductible                         | MAP Plus - Option 2 High Deductible                        | CIGNA HMO National                      |
| Contact Information | 888-488-4488<br>610-336-1000 outside U.S.<br>www.aetna.com | 888-488-4488<br>610-336-1000 outside U.S.<br>www.aetna.com | 800-CIGNA24 (244-6224)<br>www.cigna.com |

| <b>Plan Costs</b>                         |                                    |                                     |                    |
|---|------------------------------------|-------------------------------------|--------------------|
| Plan Name                                 | MAP Plus - Option 1 Low Deductible | MAP Plus - Option 2 High Deductible | CIGNA HMO National |
| <b>Employee Only</b>                      |                                    |                                     |                    |
| Subsidized Rates <sup>1</sup>             | \$138.00                           | \$30.00                             | \$143.00           |
| COBRA Rates                               | \$752.43                           | \$337.17                            | \$757.53           |
| <b>Employee + Spouse/Domestic Partner</b> |                                    |                                     |                    |
| Subsidized Rates <sup>1</sup>             | \$317.00                           | \$69.00                             | \$328.00           |
| COBRA Rates                               | \$1,504.87                         | \$674.35                            | \$1,515.06         |
| <b>Employee + Child(ren)</b>              |                                    |                                     |                    |
| Subsidized Rates <sup>1</sup>             | \$272.00                           | \$59.00                             | \$282.00           |
| COBRA Rates                               | \$1,294.19                         | \$579.94                            | \$1,302.95         |
| <b>Employee + Spouse/DP + Child(ren)</b>  |                                    |                                     |                    |
| Subsidized Rates <sup>1</sup>             | \$466.00                           | \$101.00                            | \$483.00           |
| COBRA Rates                               | \$2,219.67                         | \$994.66                            | \$2,234.72         |

<sup>1</sup> 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).

| <b>Annual Plan Limits</b>                               |   |   |  |                |                    |
|---|---|---|--|----------------|--------------------|
| Plan Name   | MAP Plus - Option 1 Low Deductible            |   | MAP Plus - Option 2 High Deductible        |                | CIGNA HMO National |
| Network Type  | In-Network                                    | Out-of-Network  | In-Network                                 | Out-of-Network | In-Network         |
| Deductible: Individual                                  | \$125   | \$500   | \$2,000                                    | \$4,000        | \$250              |
| Deductible: Family                                      | EE+1: \$250<br>EE+2 or more: \$375            | EE+1: \$1,000<br>EE+2 or more: \$1,500<br>Note: Benefits paid based on Plan Allowable Amount after annual deductible. | \$4,000 with max of \$2,800 for one person | \$8,000        | \$500              |
| 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        | \$3,000            |
| 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       | \$6,000            |

| <b>Office Visits</b>                     |  |   |   |   |   |
|--|--|---|---|---|---|
| Plan Name                                | MAP Plus - Option 1 Low Deductible               |   | MAP Plus - Option 2 High Deductible                                   |   | CIGNA HMO National                        |
| 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) |
| 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   | \$10 copay                                |
| 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 | \$35 copay; 60 days combined              |
| 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                                |

| <b>Maternity Care</b>                 |  |                                 |                                     |                                 |   |
|---------------------------------------|--|---------------------------------|-------------------------------------|---------------------------------|---|
| Plan Name                             | MAP Plus - Option 1 Low Deductible           |                                 | MAP Plus - Option 2 High Deductible |                                 | CIGNA HMO National  |
| 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 for initial visit; remaining pre/post-natal visits covered at 90% after deductible |
| 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 | Covered at 90% after deductible   |

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| Hospital Services                     |  |  |  |   |   |
|---------------------------------------|--|--|--|---|---|
| Plan Name                             | MAP Plus - Option 1 Low Deductible   |  | MAP Plus - Option 2 High Deductible  |   | CIGNA HMO National  |
| 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   | Covered at 90% 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   | \$100 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   | Covered at 90% 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   | Covered at 100% in doctor's office or independent lab; covered at 90% after deductible at outpatient facility                                       |
| Outpatient Lab                        | Covered at 100%  | Covered at 70% after deductible  | Covered at 80% after deductible  | Covered at 60% after deductible   | Covered at 100% in doctor's office or independent lab; covered at 90% after deductible at outpatient facility                                       |
| Urgent Care                           | \$20 copay after deductible  | Covered at 70% after deductible  | Covered at 80% after deductible  | Covered at 60% after deductible   | \$50 copay  |
| Mental Health / Substance Abuse       |  |  |  |   |   |
| Plan Name                             | MAP Plus - Option 1 Low Deductible   |  | MAP Plus - Option 2 High Deductible  |   | CIGNA HMO National  |
| 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   | Covered at 90% after deductible   |
| Mental Health: Outpatient             | \$20 copay   | Covered at 70% after deductible  | Covered at 80% after deductible  | Covered at 60% after deductible   | \$20 copay for office visit, 10% coinsurance for other services   |
| 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   | Covered at 90% after deductible   |
| Substance Abuse: Outpatient           | \$20 copay   | Covered at 70% after deductible  | Covered at 80% after deductible  | Covered at 60% after deductible   | \$20 copay for office visit, 10% coinsurance for other services   |
| Ancillary Services                    |  |  |  |   |   |
| Plan Name                             | MAP Plus - Option 1 Low Deductible   |  | MAP Plus - Option 2 High Deductible  |   | CIGNA HMO National  |
| 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 100%   |
| Prescription Coverage                 |  |  |  |   |   |
| Plan Name                             | MAP Plus - Option 1 Low Deductible   |  | MAP Plus - Option 2 High Deductible  |   | CIGNA HMO National  |
| 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 out-of-pocket is combined with medical   |
| Pharmacy Limits                       | Rx deductible: \$100/\$200/\$300<br>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   | Greater of 20% or \$7; \$100 copay maximum per script; 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 | Greater of 30% or \$30 formulary, greater of 40% or \$50 non-formulary; \$100 copay maximum per script; 30-day supply (open formulary)              |
| 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   | \$2 copay per script, for 30-day supply limit; subject to certain Rx  |
| Mail Order Limits                     | Rx deductible: None<br>Rx Out-of-Pocket Max combined with medical  |  | Deductible and Out-of-Pocket Maximum combined with medical   |   | 90-day supply limit on all mail order drugs   |
| Mail Order                            | Covered at 80% generic and preferred brand, 70% non-preferred brand  |  | Covered at 80% after deductible  |   | Greater of 20% or \$16 generic, greater of 30% or \$85 formulary brand, greater of 40% or \$145 non-formulary brand; \$200 copay maximum per script |

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.