Summary Plan Description Wrapper for:

The International Medical and Dental Plan of

The Dow Chemical Company Insured Health Program

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

This Summary Plan Description (SPD) is updated annually and supersedes all prior SPDs.

Content Steward: M. Theis
Date of Last Modification: January 1, 2014
Literature # 318-60504

THE DOW CHEMICAL COMPANY
ADOPTION OF SUMMARY PLAN DESCRIPTIONS

WHEREAS, The Dow Chemical Company ("Dow") sponsors The Dow Chemical Company Insured Health Program (the "Program");

WHEREAS, Dow offers the International Medical and Dental Plan (the "Plan") under the Program;

WHEREAS, Dow reserves the right, by action of the undersigned, to amend or modify the Program including, without limitation, the Plan and the Summary Plan Description for the Plan, in accordance with Article VII of the plan document for the Program; and

WHEREAS, Dow wishes to adopt a revised Summary Plan Description for the Plan.

NOW, THEREFORE, BE IT RESOLVED, Dow adopts the following Summary Plan Description for the Plan as amended and restated substantially in the form attached hereto and bearing the following cover:

> Summary Plan Description Wrapper for:
>
> The International Medical and Dental Plan of
> The Dow Chemical Company Insured Health Program
>
> Amended and Restated
> Effective January 1, 2014 and thereafter until superseded

RESOLVED, FURTHER, that all prior versions of the foregoing Summary Plan Description for the Plan are superseded.

* * * *

By: _____
Bryan Jendretzke
Global Benefits Director
The Dow Chemical Company

Reviewed by Plan Administrator:

_____
Diane Dittenhafer

Reviewed by Legal Department:

_____
Kenneth H. Hemler

Dated: December 19, 2014

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Introduction

This booklet is the Summary Plan Description Wrapper ("SPD Wrapper") for the International Medical and Dental Plan (the "Plan"), which is one of the plans offered through The Dow Chemical Company Insured Health Program (the "Program"). The Plan first became effective on July 1, 2002.

This SPD Wrapper, together with the materials provided by the Plan constitutes the "Summary Plan Description" ("SPD") for the applicable Plan.

The Plan is governed by the plan document for the Program, which is the legal instrument under which the Program is operated. This legal instrument is referred to in this SPD as the "Plan Document." If there is any inconsistency between this SPD and the Plan Document, the Plan Document shall govern. You may request a copy of the Plan Document from the Plan Administrator at the contact information listed in *Section 1. ERISA Information*.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and the Plan offered under the Program) at any time in its sole discretion.

This SPD, the Plan and the Program do not constitute a contract of employment.

Capitalized words in this SPD are defined in the Plan Document, in *Section 21. Definitions* or in the materials provided by the Plan. When used in this Summary Plan Description and communications to Employees, "Dow" refers to The Dow Chemical Company, and certain of its subsidiaries and affiliates that The Dow Chemical Company has authorized to participate in this Plan.

Section 1. ERISA Information

Type of Plan:	Group health plan
Type of Plan Administration:	Benefits provided under an insured arrangement with CIGNA
Plan Sponsor:	The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Plan Administrator:	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Employer Identification Number:	38-1285128
CIGNA Insurance Policy Number:	02002A
Plan Number:	601

Claims Administrators for Claims for Plan Benefits:	*To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits:*: CIGNA Global Health Benefits Service Center P.O. Box 15050 Wilmington, DE 19850 U.S.A. 800.441.2668 or 302.797.3100 (reverse charges accepted) www.CignaEnvoy.com Customer Service
Claims Administrators for Claims for an Eligibility Determination:	*To submit a Claim for an Eligibility Determination:* North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 U.S.A. (877) 623-8079 *To appeal a denied Claim for an Eligibility Determination:* Associate Director of North America Benefits/Global Benefits Director The Dow Chemical Company Employee Development Center Midland, Michigan 48674 U.S.A.
For Active Employees: **Contact the HR Service Center**	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (877) 623-8079
For Retirees: **Contact the Retiree HR Service Center**	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661
To Serve Legal Process File with:	Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, Connecticut 06152
COBRA	Towers Watson BenefitConnect COBRA Service Center PO Box 919051 San Diego, CA 92191-9863 (877) 292-6272
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.

Funding	The Dow Chemical Company and Participating Employers share the premium costs with Employees. Benefits are fully insured by Cigna Health and Life Insurance Company (CIGNA). CIGNA is responsible for paying applicable benefits under the Plan, not The Dow Chemical Company or any Participating Employer. Assets of the Program, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses can include, and are not limited to, consulting fees, actuarial fees, attorney fees, third-party administrator fees and other administrative expenses.
Expatriate Plan	The Plan is considered an expatriate health plan under federal guidance related to health care reform. Accordingly, Plan coverage provided under the Plan is not subject to the coverage mandates and prohibitions for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA"). The Plan may choose to comply with these requirements. See *Expatriate Health Plan* in *Section 10. Notices* for more information.

Section 2. Eligibility

2.1 Eligibility for Employees

You are eligible for medical coverage under the Plan if you are an active, regular, Full-Time or Less-than-Full-Time Salaried Employee, or Bargained-for Employee whose collective bargaining agreement provides for eligibility under the Plan, and you either:

- Are designated by Dow as having expatriate status and are on a short- or long-term international assignment for at least 6 months, as coordinated by Dow's Global Mobility department; or
- Were covered under the Private Patient Plan on June 30, 2002.

Eligibility for benefits under the Program may continue during certain benefit-protected leaves of absences approved by the Participating Employer such as under the Company's Military Leave Policy, Family Leave Policy or Medical Leave Policy. The benefits under the Program shall be administered consistent with the terms of such approved leaves of absences. In addition, eligibility may continue for repatriation periods of up to one month if you go on consecutive international assignments.

2.2 Eligibility for Retirees

You are eligible for medical (but not dental or vision) coverage under the Plan if either :

- You are a Retiree and--
  - ➢ You worked for a Dow entity that provides retiree medical coverage to its eligible retirees or you worked for Dow in a country that provides government-sponsored retiree medical coverage (not including U.S. Medicare);

  - ➢ You would have otherwise been eligible for such retiree medical coverage had you not been requested by Dow to relocate internationally to perform services for Dow; and
  - ➢ You are not a U.S. citizen living in the U.S.; or
- You were covered under the Private Patient Plan on June 30, 2002, and, at the time of your Retirement, you are not eligible for coverage under any other retiree medical program sponsored by Dow or entity 50% or more owned by Dow, or national health coverage provided by the government of the country from which you retire (including U.S. Medicare).

Retirees are not eligible for dental or vision coverage.

2.3 Dependents

Eligible Employees and Retirees can enroll their eligible Dependents. A Dependent may be:

- For Employees: your Spouse or (if the law of the applicable country permits coverage for Domestic Partners) your Domestic Partner.
- For Retirees: your Spouse of Record or (if the law of the applicable country permits coverage for Domestic Partners) your Domestic Partner of Record.
- Your Dependent Child(ren).

You must be enrolled in order to enroll a Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) or Dependent Child.

Spouse of Record or Domestic Partner of Record

For Retirees, your Spouse of Record/Domestic Partner of Record is generally your Spouse or Domestic Partner as of your Retirement. If you marry, remarry or enter into a new Domestic Partnership after Retirement, your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow sponsored retiree medical program.

However, if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married.

Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement and the exception described in the previous paragraph does not apply, your new Spouse's or Domestic Partner's children (e.g., your step-children) who are not your birth or legally adopted children are not generally eligible for coverage under any Dow-sponsored retiree medical program.

Spousal and Domestic Partner Exclusions

Your Spouse or Domestic Partner (if you are an Employee) or your Spouse of Record or Domestic Partner of Record (if you are a Retiree) is not eligible for coverage under the Plan if he or she is:

- Enrolled for coverage as an Employee or Retiree (or other former Employee) under another Dow or Dow–affiliated medical plan;
- An Employee and you are a Retiree. See *Dual Dow or UCC Employees;* or
- Serving in the armed forces of any country.

When your Spouse or Domestic Partner is no longer eligible for coverage because of one of the above events, contact the HR Service Center or the Retiree Service Center within 90 days.

Coordination of Benefits

If your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) has enrolled in coverage offered by his or her employer (or former employer), the payment of benefits under the Plan will be secondary to your Spouse/Domestic Partner's (or for Retirees, Spouse of Record/Domestic Partner of Record's) coverage through his or her employer (or former employer) under the Plan's coordination of benefits rules.

There is no requirement for your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) to enroll your Dependent Child(ren) in your Spouse/Domestic Partner's (or for Retirees, Spouse of Record/Domestic Partner of Record's) coverage in order for you to cover them as Dependents under the Program. If you decide to enroll your eligible Dependent Child(ren) in both the Plan and your Spouse/Domestic Partner's (or for Retirees, Spouse of Record/Domestic Partner of Record's) employer's coverage, benefits for the Dependent(s) will be coordinated between the two plans. When determining how benefits under the Plan will be paid (or the amount of benefits paid) with respect to the Dependent(s), the Plan's benefits will be coordinated using the birthday rule (see the Coordination of Benefits description in the materials provided to you by CIGNA).

Waiving Coverage – Working Spouse/Domestic Partner

You should consider carefully whether it is advantageous to enroll your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) as a Dependent under the Program if the coverage offered by his or her employer is as comprehensive or better than the Program's. Any Plan in which you enroll your Spouse/Domestic Partner would be secondary to your Spouse/Domestic Partner's medical plan under the Dow coordination of benefits rules, as explained in *Coordination of Benefits*, above. You may choose to waive coverage for your Spouse/Domestic Partner under the Program in order to save premium dollars. If you waive coverage under the Program, then no coordination of benefits will occur.

Definition of "Dependent Child":

A child is eligible for coverage under the Program if the child meets the definition of "Dependent Child." A "Dependent Child" is a child who must be:

- your birth or legally adopted child; or
- your Spouse's or Domestic Partner's natural or adopted child (or, for Retirees, must be your Spouse or Record or Domestic Partner of Record's natural or adopted child); or
- a child for whom you or your Spouse or Domestic Partner (for Retirees, your Spouse of Record/Domestic Partner of Record) have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently "legally relinquished all of their parental rights" in a court of law. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:
  - authority to consent to the child's marriage or adoption, or
  - authority to enlist the child in the armed forces of the U.S.;
  - right to the child's services and earnings; and
  - power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

To enroll your Domestic Partner's child(ren), your Domestic Partner must meet the Program's definition of Domestic Partner; you must have completed a valid "Statement of Domestic Partner Relationship" form and placed it on file with the Program.

Note: As indicated above, if you are a Retiree and your Spouse/Domestic Partner is *not* your Spouse of Record/Domestic Partner of Record (for example, because you married after your Retirement), the child of your Spouse/Domestic Partner is eligible for coverage only if the child is your birth or legally adopted child or you have permanent legal guardianship or custody for the child. However, you are permitted to continue coverage for the birth or adopted child of your Spouse/Domestic Partner, or a child for whom your Spouse/Domestic Partner has permanent legal guardianship or custody, if the child was covered as your Dependent under Dow retiree medical coverage prior to March 1, 2013, and remains continuously covered under Dow retiree medical coverage.

Dependent Child(ren) Exclusions

Your Dependent Child will *not* be eligible for coverage under the Program if he or she:

- *Reaches age 26.* In general, coverage ends on the child's 26th birthday. Children age 26 or older are not eligible, unless otherwise required by applicable law, or unless, prior to age 26, the child is incapable of self-sustaining employment because of a physical or mental disability and is covered under the Plan on the day prior to reaching age 26. The disabled child must be principally dependent upon you for support. Proof of the child's initial and continuing dependency and disability must be provided to the Plan prior to age 26 in order for coverage to continue. You must make any contribution required by the Plan to continue coverage for your child. Once coverage is terminated, it cannot be reinstated. Contact the HR Service Center or the Retiree Service Center for more information; or
- *Is covered as a Dependent under a Dow-sponsored medical plan.* All eligible children in a family must be covered by the same parent. (Exceptions may be made as necessary in stepchild situations.)

When your child is no longer eligible for Dependent coverage because of one of the above events, you must make a new enrollment within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs. For information about rights your child may have for continuation of coverage under the Program as provided by the federal COBRA law, see *Section 9.2 COBRA Continuation Coverage*. Note: In order for your Dependent to receive COBRA continuation coverage, you must provide notice that your child is no longer an eligible Dependent within 60 days after your Dependent becomes ineligible.

Eligibility through Qualified Medical Child Support Orders

A child who does not qualify as a "Dependent Child" above may still be eligible for coverage if an eligible Employee or Retiree has a "Qualified Medical Child Support Order" for that child. A Qualified Medical Child Support Order ("QMCSO") is a court order that meets the Program's requirements to provide a child the right to be covered under one of the Plans offered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Program.

Typically, a divorce decree that orders the Employee or Retiree to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree (or a document signed by either the Employee, Retiree or the custodial parent, provided with the divorce decree, and consistent with the divorce decree) contains the following information:

- The name and last known mailing address of each child for whom the Employee or Retiree must provide medical coverage;
- A reasonable description of the type of coverage to be provided to the child; and
- The period for which the coverage is to be provided (within the Program's rules).

Note that if there is any ambiguity in, or between, the document(s) signed by the Employee or custodial parent, the Program reserves the right to require the Employee and/or custodial parent to obtain a court order to resolve the ambiguity.

You may obtain a free copy of the Program's QMCSO procedures, which explain how the Program determines whether a court order meets the Program's requirements, by requesting a copy from the Plan Administrator at the contact information in *Section 1. ERISA Information*.

2.4 If You Are Medicare-Eligible

You are not eligible for coverage under this plan if you are eligible for Medicare.

2.5 Eligibility Determinations of Claims Administrator Are Final and Binding

The applicable Claims Administrator determines eligibility. The Claims Administrator is a fiduciary of the Program and has the full discretion to interpret provisions of the SPD and the Plan Document and to make findings of fact. However, the Claims Administrator's determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants. If you would like the applicable Claims Administrator to determine whether you are eligible for coverage, you can file a Claim for an Eligibility Determination. See *Section 7. Claims Procedures*.

Section 3. Enrollment

3.1 Levels of Participation

The levels of participation available are:

- Employee Only or Retiree Only
- Employee plus Spouse or Retiree plus Spouse of Record
- Employee plus Domestic Partner or Retiree plus Domestic Partner of Record
- Employee plus Child(ren) or Retiree plus Child(ren)
- Employee plus Spouse and Child(ren) or Retiree plus Spouse of Record and Child(ren)
- Employee plus Domestic Partner and Child(ren) or Retiree plus Domestic Partner of Record and Child(ren)

You must be enrolled in order to enroll your Dependent.

After enrolling you will receive an identification card showing the phone number to call with questions you may have, or to verify coverage.

3.2 Enrolling as an Active Employee

You must enroll within 90 days of your date of hire. If you are on international assignment to or from the U.S., enroll on the Dow Benefits web site or enroll by calling the HR Service Center. For all other new

hires, complete the enrollment form available on the Mobility web site, or call the HR Service Center for a copy of the form.

- *If your enrollment is received within 31 days of your first day at work*, coverage is effective on your date of hire.
- *If your enrollment is received more than 31 days after your first day at work, but within 90 days of your first day at work*, coverage begins as soon as practicable after your enrollment request is received (provided that you are still actively at work).

If you do not enroll within 90 days of your date of hire, you will not have coverage, and you will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 4. Mid-Year Election Changes*).

The Program reserves the right, at any time, to request proof of Dependent eligibility, if you are enrolling your Spouse/Domestic Partner and/or Dependent Child(ren). If requested, proof of their eligibility must be provided within 90 days of your date of hire. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

If proof of Dependent eligibility is requested and you do not provide it within 90 days after your first day at work:

1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan.

2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for your Dependent. See *Section 18. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while your Dependent was not eligible for coverage.

3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, coverage will terminate as of the 90th day after your date of hire.

4. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11.5 Fraud*.

3.3 Annual Enrollment (for Active Employees or Eligible Retirees)

Annual enrollment is typically held during the last quarter of the year. You may enroll for coverage, switch to a home or host country plan (where permitted), or waive coverage at this time. If you wish to add a Dependent – either a Spouse/Domestic Partner (Spouse of Record/Domestic Partner of Record) or a child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. If requested, you must provide proof of Dependent eligibility no later than March 31st of the applicable Plan Year. Required documentation may include a Marriage certificate, Domestic Partner

signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

If you do not provide proof of Dependent eligibility by March 31st:

1 You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan (i.e., January 1st).

2 If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for your Dependent. See *Section 18. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while your Dependent was not eligible for coverage.

3 If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of March 31st.

4 If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11.5 Fraud*.

If your Spouse is enrolled in a Plan, you may not dis-enroll your Spouse in anticipation of a divorce. You are required to continue coverage for your Spouse and pay the applicable premium. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), when your legal separation or divorce is final, your Spouse has a right to continue coverage under the Plan at 102% of the full cost of coverage for a certain period of time. See *Section 9.2 COBRA Continuation Coverage* for more information about COBRA coverage.

3.4 Default Enrollment

If at annual enrollment you fail to enroll or affirmatively waive coverage under the Plan within the time period specified in the annual enrollment brochure, your current medical plan elections will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible for the coverage in which you are enrolled.

3.5 Enrolling at Retirement

The Plan is available to Retirees in very specific circumstances. See *Section 2.2 Eligibility for Retirees*. If you are eligible for coverage under the Plan, you may enroll only if you are not eligible for a Dow retiree medical plan in any country. For example, if you are eligible for medical coverage as a retiree in Germany, but choose to live in the United States where the German plan will not cover you, you are not eligible for the Plan.

To enroll for Program coverage upon your Retirement, enroll within 31 days after your Retirement on the Dow Benefits web site or by calling the Retiree Service Center. If you do not enroll yourself and/or your eligible Dependents within 31 days after Retirement, you and/or they will not be covered. You will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 4. Mid-Year Election Changes*).

If you are enrolling your Spouse of Record/Domestic Partner of Record and/or Dependent Child(ren), you must provide proof of their eligibility within the timeframe requested by the Plan Administrator. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers, or any other proof the Plan Administrator deems appropriate. If you do not provide proof of Dependent eligibility within the timeframe required by the Plan Administrator:

1 You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan.

2 If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Plan may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for your Dependent. See *Section 22. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while your Dependent was not eligible for coverage.

3 If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of the date your proof of Dependent eligibility was required by the Plan Administrator.

4 If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11.5 Fraud*.

3.6 Dual Dow or UCC Employees

If you and your Spouse/Domestic Partner are each independently eligible for coverage under a Dow-sponsored (which includes heritage Rohm and Haas) or Union Carbide-sponsored medical plan, the following rules apply:

- You may each enroll separately, or one of you may enroll the other as a Dependent; except that an Employee may not be enrolled as a Dependent in a retiree medical plan.
- If you each enroll separately, either of you, but not both, may enroll your eligible Dependent Child(ren). (This rule also applies to divorced parents who are independently eligible for coverage.)
- If you each enroll separately, your deductibles and out-of-pocket maximums will be calculated separately. (This rule also applies to divorced parents who are independently eligible for coverage.)

3.7 Changes of Election to Prevent Discrimination

The Plan Administrator has the authority to change the benefit elections of certain Participants if such a change is necessary to prevent the Program from becoming discriminatory within the meaning of Section 125(b) of the Internal Revenue Code (the "Code"). If the Plan Administrator determines or is informed by the plan administrator of The Dow Chemical Company Flexible Spending Plan (the "Dow Flexible Spending Plan") before or during any plan year that the Dow Flexible Spending Plan may fail to satisfy, for such plan year, any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to key Employees or Highly Compensated Employees, the Plan Administrator shall

take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or key Employees with or without the consent of such Employees.

Section 4. Mid-Year Election Changes

In general, if you are an Employee subject to U.S. income tax, you purchase your Employee, Spouse (or Spouse of Record), and Dependent Child coverage under the Plan with premiums that are pre-tax dollars through the Dow Flexible Spending Program, a plan intended to qualify under Section 125 of the Code as a "cafeteria plan."

Unless otherwise permitted by the Plan Administrator in his or her sole discretion, you may change your medical coverage level only during annual enrollment, or if you have a special enrollment event or a "change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan). For Retirees, the Program administers changes in status events and the consistency rules the same way as for active Employees, except that you may drop a Dependent from coverage at any time other than in anticipation of a divorce (as required by the COBRA rules).

Because of IRS rules, Domestic Partner (or Domestic Partner of Record) coverage and coverage for children of a Domestic Partner who are not your tax dependents are generally purchased with post-tax dollars. The Program administers change in status events and the consistency rules the same way with respect to Domestic Partners as Spouses, regardless of the post-tax treatment by IRS, to the extent that such administration does not jeopardize the tax qualified status of the Program.

4.1 Special Enrollment Provisions

You may be eligible to enroll in the Plan outside of annual enrollment if one of the following special enrollment events occurs:

- ***Loss of Other Medical Coverage.*** If you decline enrollment in the Plan for you or your Dependent(s) (including your eligible Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependents outside of the usual annual enrollment period if you or your Dependent lose eligibility for the other coverage or the other employer ceases to make employer contributions for the other coverage. In order to have coverage under the Plan, you or your eligible Dependent must enroll in the Dow-sponsored coverage within 90 days after the other coverage ends. However, if you or your Dependent declined Dow-sponsored coverage because of other coverage provided through COBRA, you or your Dependent must wait until the annual enrollment period unless the entire period of coverage available under the COBRA coverage has been exhausted. An individual need not elect COBRA coverage under another health plan in order to use these special enrollment provisions.
- ***Marriage, Birth, or Adoption.*** If you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may receive coverage under the Plan for yourself and your new Dependent (and, if you are an Employee, your new Spouse/Domestic Partner) if you enroll in the Plan within 90 days after the Marriage, Domestic Partnership, birth, adoption, or placement for adoption.
- ***Loss of Medicaid or SCHIP.*** If you or your Dependent either (i) loses coverage under Medicaid or a State Child Health Insurance Plan ("SCHIP"), or (ii) becomes eligible for premium assistance under the Plan through Medicaid or SCHIP, you may receive coverage for yourself and your Dependent if you enroll within 90 days.

In order to enroll in the Plan because of a special enrollment event described above, you must provide proof of the event in accordance with *Section 4.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *Section 4.9 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 4.9 Deadline to Enroll for Mid-Year Changes*.

4.2 Change in Status

A "change in status" is an event listed in one of the bullets below:

- An event that changes your legal marital status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record), divorce, annulment, or Termination of Domestic Partnership.
- An event that changes your number of Dependents, including birth, adoption, placement for adoption or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse /Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or Dependent Child.
- Dependent satisfies or ceases to satisfy the definition for "Dependent Child."
- A change in the place of residence or work for you or your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or Dependent Child.
- Your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or Dependent Child gains eligibility for coverage under his or her employer's health plan.

4.3 Consistency Rule

In addition to having a "change in status," you also must meet all of the following consistency rules.

- The change in status must result in you, your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or your Dependent Child gaining or losing eligibility for coverage under either the Dow-sponsored plan or the parallel plan of your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) or Dependent Child's employer.
- The election change to the Dow-sponsored plan must correspond with that gain or loss of coverage.

4.4 Exceptions to the Change in Status and Consistency Rules

You may change your medical coverage levels mid-year without having met the change in status and consistency-rule requirements only under the following circumstances:

- **Court Orders** – You may change your election mid-year if a court order resulting from a divorce, annulment or change in legal custody (including a Qualified Medical Child Support Order, or QMCSO), requires a change in your medical plan election.
- **Entitlement to Medicare or Medicaid** – If you, your Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record, or Dependent are enrolled in the Program and become entitled to coverage (i.e., enrolled) under Medicare or Medicaid mid-year (other than for coverage consisting solely for distribution of pediatric vaccines), you may cancel your Program coverage.

- **Significant Cost or Coverage Changes** – If your Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record is covered by his or her employer's plan, which allows him or her to change his or her benefit plan election because of a significant change in cost or coverage under the employer's plan, such change in your Spouse/Domestic Partner's election will allow you to change your Dow election. If your Spouse/Domestic Partner's employer's enrollment period is different from Dow's, your Spouse/Domestic Partner's election under his or her employer's plan may constitute a significant coverage change allowing you to change your Program election.
- **Special Enrollment Rights** – You may change your Program election mid-year if you meet the special enrollment requirements addressed in *Section 4.1 Special Enrollment Provisions*.

4.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated change you are permitted to make. Application of the rules above may differ for Retirees and former Employees. Any change is subject to meeting the Dependent eligibility rules and the eligibility rules for the relevant coverage option, as applicable.

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll, you may increase your level of participation (*e.g.,* Employee Only to Employee plus Spouse), or you may change to a different coverage option (*e.g.,* from the Plan to another Dow medical plan, if any, for which you are eligible).
Lose a Dependent • Divorce • Death • Dependent loses eligibility • Termination of Domestic Partnership	You may decrease your level of participation (*e.g.,* Employee plus Spouse to Employee Only). You may not change to a different coverage option (*e.g.,* from the Plan to another Dow medical plan, if any, for which you are eligible).
Spouse/Domestic Partner loses medical coverage elsewhere	You may enroll, increase your level of participation (*e.g.,* Employee Only to Employee plus Spouse), or change to a different coverage option (*e.g.,* from the Plan to another Dow medical plan, if any, for which you are eligible).*
Repatriate to home country from an Assignment	Upon repatriation, you are no longer eligible for this Plan and would be eligible to enroll for benefits based on the rules in your home country.

4.6 Documentation of Eligibility Required to Make Election Change

Documentation is generally required to show proof of eligibility to make an election change and/or to show proof of Dependent eligibility. Required documentation may include birth certificates, passports,

Marriage certificates, Domestic Partner signed statements, Social Security Numbers, evidence of loss of Spouse/Domestic Partner's (or for Retirees, Spouse of Record/Domestic Partner of Record's) or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Plan reserves the right to, at any time, request proof of eligibility.

In general, you are required to provide proof of eligibility to make an election change and/or proof of Dependent eligibility by day 90 after the change in status or special enrollment event. If you do not provide such proof within 90 days after the change in status or special enrollment event:

1 You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that you and/or your Dependent was enrolled in the Plan.

2 If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for you and/or your Dependent retroactive to the first day that you and/or your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for you and/or your Dependent. See *Section 18. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent was not eligible for coverage.

3 If you pay 102% of the full cost of coverage but you do not provide acceptable proof of eligibility by the date determined by the Plan Administrator, coverage will terminate as of the 90th day after the change in status or special enrollment event.

4 If, by the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of eligibility, you and/or your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11.5 Fraud*.

4.7 Dropping a Dependent

You may drop an ineligible Dependent by updating your enrollment information on the Dow Benefits web site, using the enrollment form on the Mobility web site, or notifying the HR Service Center or the Retiree Service Center, as applicable. As explained in *Section 9.1 When Coverage Ends*, if you or your Dependent is no longer eligible for coverage, you must update your enrollment information using one of the methods described above; otherwise, you will continue to be obligated to pay premiums until the date the HR Service Center or the Retiree Service Center processes your updated enrollment information, coverage may be dropped retroactively, and you may be required to reimburse the Plan for any medical benefits already paid.

If you are a Retiree, you may drop a Dependent at any time for any reason (except in anticipation of a divorce, as required by the COBRA rules).

4.8 Dropping or Adding a Domestic Partner

The Program will cease to recognize a Domestic Partnership as of the date stated on a valid "Termination of Domestic Partner Relationship" form filed with the Plan Administrator.

After you file a "Termination of Domestic Partner Relationship" form with the Plan Administrator, you must wait at least twelve (12) months before you may add a new Domestic Partner as your Dependent (eligible only if you are an Employee). At that time, you must file a new Statement of Domestic Partner Relationship form for the new Domestic Partner.

4.9 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the Fall of each year), you must submit the required proof of eligibility and request enrollment within 90 days of the change in status or special enrollment event (or within 180 days for geographic relocation under the Participating Employer's relocation policy) in order to avoid being charged 102% of the full cost of coverage.

The effective date of a mid-year election change will be as follows:

- For the birth of a child, the date of birth.
- For the adoption of a child, the earlier of the date of adoption or date of placement for adoption.
- For a court order, the date specified in the court order.
- In all other cases:
  - If the Plan Administrator receives your enrollment request within 31 days of the change in status or special enrollment event, the effective date of the mid-year election change will be the date of the event.
  - If the Plan Administrator receives your enrollment request on day 32 through 90 after the change in status or special enrollment event, the effective date of the mid-year election change will be the Plan Administrator's processing date.

Section 5. Premiums

5.1 Employee Premiums

If you are subject to U.S. income tax law, you and Dow share the premium costs for your medical coverage. Your contributions to premiums are paid through payroll deductions. For your portion of the monthly premium, refer to the materials provided during the annual enrollment period.

Contributions for coverage for you, your Spouse and/or your Dependent Child(ren) are deducted on a pre-tax basis. Because of IRS regulations, contributions for Domestic Partner coverage are deducted on a post-tax basis. Coverage for children of Domestic Partners also must generally be paid on a post-tax basis, unless the child is your dependent and cannot be claimed as a dependent on someone else's tax return, such as your Domestic Partner's tax return.

If the last payroll period for a Plan Year occurs partly during a current Plan Year and partly during the next Plan Year, the Plan Administrator has the full and complete discretion to modify your contributions in any way that the Plan Administrator deems administratively efficient, including modifying your contributions for the last payroll period without your consent.

5.2 Leaves of Absence

During certain approved leaves of absences, coverage under the Program may continue if the required premiums are paid. During paid leaves of absences, the premiums must be paid by payroll deduction or any other means the Plan Administrator deems appropriate or necessary to collect the premiums.

If you take an approved unpaid leave of absence under the Participating Employer's Family or Medical Leave Policy, the Plan Administrator will continue to maintain your Plan benefits during the approved leave on the same terms and conditions as if you were still an active Employee. You must pay your share of the premium in one of the ways described below. Unless you provide written notification to the Plan Administrator at least two (2) weeks prior to the beginning of the leave as to which method of payment you select, method three (3) is the default:

- With after-tax dollars, by sending monthly payments to the Plan Administrator by the due date established by the Plan Administrator.
- With pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation.
- The Employer may fund coverage during the leave and withhold "catch up" amounts upon your return.
- Under another arrangement agreed upon between you and the Plan Administrator.

If your coverage ceases while on family or medical leave, you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave.

5.3 Failure to Pay Required Premiums

Your failure to pay the full amount of premiums due by the date required by the Plan Administrator may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. The Plan Administrator, in its sole discretion, may determine whether you are delinquent in paying premiums. In general, you are considered delinquent if required premiums are more than 90 days past due. If you become delinquent in paying premiums:

- You must reimburse the Plan for premiums you did not pay during any period in which you received coverage under the Plan.
- Your Dow medical coverage (including coverage for your Dependent(s)) may be terminated on a prospective basis, or retroactive as of the date for which required premiums were not paid.
- Before you re-enroll for Dow medical coverage, you must first reimburse the Plan for any unpaid premiums you owe, and you may be required to pay 102% of the full cost of coverage for the remainder of the Plan Year.

The Plan reserves the right to require you to pre-pay premiums in order to receive coverage.

In addition, the provisions of *Section 22. Payment of Unauthorized Benefits*, may apply if benefits were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

5.4 Excess Premium Payments

If you enrolled for Dependent coverage and failed to provide proof of Dependent eligibility satisfactory to the Plan Administrator or to notify the Plan Administrator of a Dependent's ineligibility within the required time period, and/or the Plan Administrator determines that your Dependent(s) is (are) not eligible for coverage, the Program reserves the right not to refund the premiums you paid, and to cancel coverage of your Dependent(s) retroactive to the date you enrolled your Dependent(s). In addition, the Plan Administrator may require that you continue to pay premiums at the same enrollment level until you change your coverage during the next annual enrollment, even though coverage for your Dependent(s) was dropped retroactively effective to the date of ineligibility.

5.5 Retiree Premiums

You and Dow share the premium cost for Plan coverage. The premium is the cost associated with Plan coverage. The Company or Participating Employer pays part of this expense and you pay part of this expense. The portion that your Employer pays toward the premium is completely separate from benefits payable under the Plan. Retiree costs may differ from Active Employee premiums.

5.6 Retiree Premium Payments/ Excess Premium Payments

If your monthly premium amount is less than your monthly Dow pension payment amount (under any Dow-sponsored plan such as the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan), the Plan requires that your premium be paid from a deduction from your monthly pension payment. If your monthly premium amount is equal to or greater than your monthly pension payment amount, then your premium will not be deducted from your pension payment, but you will be billed for the premium.

Your failure to pay the full amount of premiums due by the date required by the Plan Administrator may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. The Plan Administrator, in its sole discretion, may determine whether you are delinquent in paying premiums. In general, you are considered delinquent if required premiums are more than 30 days past due. If you become delinquent in paying premiums:

- You must reimburse the Plan for premiums you did not pay during any period in which you received coverage under the Plan.
- Your Dow medical coverage (including coverage for your Dependent(s)) may be terminated on a prospective basis, or retroactive as of the date for which required premiums were not paid.
- Before you re-enroll for Dow medical coverage, you must first reimburse the Plan for any unpaid premiums you owe, and you may be required to pay 102% of the full cost of coverage for the remainder of the Plan Year.

The Plan reserves the right to require you to pre-pay premiums in order to receive coverage.

In addition, the provisions of *Section 11.5 Fraud Against the Plan* or *Section 18. Payment of Unauthorized Benefits* may apply if benefits were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

Section 6. If You Are Eligible for Medicare

If you are:

- a former Employee (including Retiree) who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- a former Employee's (including a Retiree) Dependent, or a former Dependent Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and you are eligible for Medicare due to disability;
- the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and you are eligible for Medicare due to disability;
- an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, and you are eligible for Medicare due to age;
- an Employee or Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after you have been eligible for Medicare for 30 months;

your coverage will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this Plan will be reduced so that the total amount payable by Medicare and by CIGNA will be no more than 100% of the expenses incurred.

CIGNA will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he or she would receive if he or she had applied for Part A.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he or she would receive if enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he or she would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

Section 7. Claims Procedures

A "Claim" is a written request by a claimant for Plan benefits or an eligibility determination. There are two kinds of Claims:

- A *Claim for Plan Benefits* is a Claim requesting that the applicable Plan pay for benefits covered under the applicable Plan.
- A *Claim for an Eligibility Determination* is a Claim requesting a determination as to whether a claimant is eligible to be a Participant under the applicable Plan or the Program or as to the amount a claimant must contribute towards the cost of coverage.

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation. The Claims Procedures for Claims for Plan Benefits are described in the materials provided to you by CIGNA.

7.1 Deadline to File a Claim

All Claims must be filed within 365 days of the date on which the service was rendered. The deadline for filing a Claim that you were overcharged for coverage is the end of the year following the year for which the premium was paid. Failure to file a Claim within the deadline will result in denial of the Claim.

7.2 Who Will Decide Whether to Approve or Deny My Claim?

The Program has more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you an appeal an initial determination, the appellate decision is made by the Appeals Administrator. Each of the Claims Administrators is a named fiduciary of the Program with respect to the types of Claims that it processes.

- For Claims for Plan Benefits, the Initial Claims Reviewer and the Appeals Administrator is CIGNA.
- For Claims for an Eligibility Determination, the Initial Claims Reviewer is the North America Health and Welfare Plans Leader, and the Appeals Administrators are the Associate Director of North America Benefits and the Global Benefits Director.

7.3 Authority of Claims Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. However, the Claims Administrators' determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Program under Section 502 of the Employee Retirement Income Security Act (ERISA) in federal court, provided you complete the claims procedures described in this *Section 7. Claims Procedures* (or the Claims Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *12.1 Litigation* for the deadline for filing a lawsuit.

7.4 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim on behalf of a Participant. The Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition also may act as your authorized representative.

7.5 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

The following information must be submitted in writing to the Initial Claims Reviewer in order to be a "Claim":

- The name of the Retiree, Employee (or former Employee), and the name of the person (Retiree, Employee or Dependent as applicable) who is requesting the eligibility determination;
- The benefit plan for which the eligibility determination is being requested (The International Medical and Dental Plan of The Dow Company Insured Health Program);
- If the eligibility determination is being requested for the Retiree's or Employee's dependent:
    - a description of the relationship of the dependent to the Retiree or Employee (e.g., Spouse/Domestic Partner, Dependent Child, etc.);
    - documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for eligibility determinations must be sent to:

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Initial Claims Reviewer for the International Medical and Dental Program of The Dow Chemical Company Insured Health Program

Initial Determination

If you submit a Claim for an Eligibility Determination, the Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days of the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer can have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer needs such an extension, it will notify you prior to the expiration of the initial 90-day period, state the reason why such an extension is needed and state when it will make its determination.

If the Initial Claims Reviewer denies the Claim, the written notification of the Claims decision will state the reason(s) why the Claim was denied and refer to the pertinent Program provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer needed additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

Appealing the Initial Determination

If the Initial Claims Reviewer has denied your Claim, you may appeal the decision. If you appeal the Initial Claims Reviewer's decision, you must do so in writing within 60 days of receipt of the Initial Claims Reviewer's determination, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator. Your written appeal must include the following information:

- The name of the Employee or Retiree;
- The name of the Dependent, if the Dependent is the person who is appealing the Administrator's decision;
- The name of the Plan (The International Medical and Dental Plan of The Dow Company Insured Health Program);
- Reference to the initial determination; and
- An explanation of the reason why you are appealing the initial determination.

Appeals of Claims for an Eligibility Determination should be sent to:

Associate Director North America Benefits or the Global Benefits Director
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Appeals Administrator of the International Medical and Dental Plan of The Dow Chemical Company Insured Health Program (Appeal of Eligibility Determination)

You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You also may request that the Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

After the Appeals Administrator receives your written request to appeal the initial determination, the Appeals Administrator will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The Appeals Administrator is not the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. The Appeals Administrator will notify you in writing of its final decision. Such notification will

be provided within a reasonable period, not to exceed 60 days of the written request for appellate review, except that under special circumstances, the Appeals Administrator can have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator needs such an extension, it will notify you prior to the expiration of the initial 60-day period, state the reason why such an extension is needed, and indicate when it will make its determination. If an extension is needed because the Appeals Administrator determines that it does not have sufficient information to make a decision on the Claim, it will describe any additional material or information necessary to submit to the Program, and provide you with the deadline for submitting such information.

The period for deciding your Claim may, in the Appeals Administrator's sole discretion, be tolled until the date you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator will decide the Claim without the additional information.

The Appeals Administrator will notify you in writing of its decision. If your claim is denied, in full or part, the written notification of the decision will state (1) the reason(s) for the denial; (2) refer to the specific provisions in the Plan Document on which the denial is based; (3) that you are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to your claim (as determined by the Claims Administrator under applicable federal regulations); and (4) that you have a right to bring a civil action under section 502 of ERISA.

7.6 How to File a Claim for Plan Benefits

You must file a Claim for Plan Benefits with CIGNA. You must follow CIGNA's claims procedures, which are described in the materials provided to you by CIGNA. You can request of copy of the claims procedures applicable to CIGNA by calling toll free at 1-800-441-2668 (If dialing internationally, use that country's AT&T access code), or call 302-797-3100 (reverse charges accepted). Or, send an email to the CIGNA Customer Service Representatives at cieb@cigna.com. You can download a claims form from www.cignaenvoy.com.

Section 8. Conditional Claim/Subrogation

The provisions of this Section 8 shall not be construed to limit or restrict in any way the subrogation or reimbursement provisions set forth in the Certificate of Insurance. Any such provisions in the Certificate of Insurance shall apply in addition to the provisions of this Section 8. In case of conflict between this Section 8 and the Certificate of Insurance, the Plan Administrator shall have exclusive authority to determine which provisions will govern.

As used in this Section 8, these terms have the following meaning:

- "Covered Person" means a Participant (including a Retiree) or a Dependent, the parents and legal guardians of a Participant or Dependent who is a minor, and the heirs, administrators, and executors of a Participant's or Dependent's estate.
- "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition, without regard to whether such party caused the illness, injury, or condition. The term "Responsible Party" includes the liability insurer of such party, any Insurance Coverage, and any employer, agent, or principal of such party.
- "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

8.1 The Program's Entitlement to Reimbursement

Subrogation. Immediately upon paying or providing any benefit under this Program, the Program shall be subrogated (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to the Covered Person's injury, illness or condition to the full extent of benefit provided or to be provided by the Program.

Reimbursement. If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Program has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Program has paid and will pay as a result of that injury, illness or condition (including attorneys' fees and other costs incurred in enforcing the Program's rights), up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Program, and the Program may pursue equitable remedies to recover the monies or withhold future benefits until reimbursement is made.

Lien Rights. The Program will automatically have a lien to the extent of benefits paid by the Program for the treatment of the illness, injury or condition for which the Responsible Party is alleged to be liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise related to any illness, injury or condition for which the Program paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Program including, but not limited to, the Covered Person; the Covered Person's representative or agent; the Responsible Party, the Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Program.

First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person acknowledges that the Program's recovery rights are a first priority claim against all Third Parties and are to be paid to the Program before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Program is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, ***even if such payment to the Program will result in a recovery to the Covered Person that is insufficient to make him or her whole*** (*i.e.*, the "make whole" doctrine will not apply).

Applicability to All Settlements and Judgments. The Program is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Program provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Program is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only (*i.e.*, the "common fund" doctrine will not apply).

Program Not Required to Pay Court Costs or Attorneys' Fees. The Program is not required to participate in or pay court costs or attorneys' fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim. Should it be necessary for the Program to institute legal action against a Covered Person (or assignee) for failure to reimburse the Program in full, or for failure to honor the Program's equitable interest in the amount recovered from a Responsible Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys' fees.

8.2 Your Responsibilities

The Covered Person is required to fully cooperate with the Program's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Program, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Program may reasonably request. The rights described in this Section 13 are assigned to the Program without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Program an assignment and other instruments that may be used to facilitate securing the rights of the Program. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

The Program may withhold future benefits or terminate the Participant *and* the Covered Person from the Program if the Covered Person does not fully cooperate with the Program's efforts to recover the benefits paid by the Program. In addition, if the Participant or the Covered Person is terminated from eligibility under *any* benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of failure to reimburse that benefit plan, the Plan Administrator may determine that the Participant and/or the Covered Person are disqualified from eligibility for coverage under the Program.

The Covered Person acknowledges by accepting benefits from the Program that the Program has the right to conduct an investigation regarding the injury, illness or condition in order to identify any Responsible Party. The Program reserves the right to notify a Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Covered Person's obligation to reimburse the Program is limited to the amount of medical benefits the Program has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. However, if the Program must institute a legal action because a Covered Person fails to reimburse the Program in full or to honor the Program's equitable interest in any recovery, the Covered person will be liable for all costs of collection, including reasonable attorneys' fees.

If the Program has overpaid you, either due to Claim payment error or third-party reimbursement, any overpayments made to you may be offset by the Program in future Claims you file.

8.3 Jurisdiction

For purposes of this Section 13, by accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Program may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

8.4 CIGNA's Right to Subrogation

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CIGNA, another party may be liable:

- CIGNA shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any

recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CIGNA's subrogation rights.

- Alternatively, CIGNA may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CIGNA the lesser of:
  - the amount actually paid for such Covered Expenses by CIGNA; or
  - the amount you actually receive from the third party for such Covered Expenses;

  at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

Section 9. Ending Coverage

9.1 When Coverage Ends

Except as otherwise provided in this 9.19.1 , a Participant's coverage ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Participant elects not to participate for the Plan Year
- The Participant's death
- Termination of the Plan or Program
- Failure to pay the required premiums
- Failure to reimburse the Program for claims paid by the Program that, under the terms of the Program, you or your Dependent are required to reimburse the Program
- Failure to comply with the terms and conditions of the Program or the Plan
- Providing false or misleading information to the Program or the Plan

When your Dependent is no longer eligible, or dies, update your enrollment information on the Dow Benefits web site, by using the enrollment form on the Mobility web site, or by contacting the Retiree Service Center or HR Service Center within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. If you qualify for a reduction in premium, the premium will be reduced effective as of the date your updated enrollment information is processed. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

If you cease to be eligible to participate in the Program due to a voluntary termination of employment and you are eligible for either The Dow Chemical Company Retiree Medical Program, the Union Carbide Corporation Retiree Medical Care Program, or the Rohm and Haas Retiree Medical Care Program, your coverage terminates on the last day of the month in which you terminate employment. If you cease to be eligible to participate in the Program and elect COBRA continuation coverage, your coverage terminates at the times described in *How is COBRA Coverage Provided?* below.

Generally, your Dependent's coverage under the Plan will terminate when your coverage terminates unless your Dependent elects COBRA (See *Section 9.2 COBRA Continuation Coverage*)

9.2 COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of coverage under the Program. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you and to other members of your family who are covered under the Program when you or they would otherwise lose group health coverage.

There may be other coverage options for you and your family and some of these options may cost less than COBRA continuation coverage. You could be eligible to buy coverage through the Health Insurance Marketplace and for a tax credit that lowers your monthly premiums. You should be able to see what your premium, deductibles, and out-of-pocket costs will be for coverage purchased through the Marketplace before you enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace (but enrolling in COBRA may affect your eligibility for a tax credit). Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after the qualifying event.

Although COBRA does not apply to Domestic Partners, the Program provides Domestic Partners (or for Retirees, Domestic Partners of Record) the same protection it provides Spouses (or Spouses of Record) that are covered under COBRA, consistent with the Program's definition and rules concerning Domestic Partners, and to the extent that it does not jeopardize the tax qualified status of the Program.

This section of the SPD generally explains COBRA continuation coverage, when it may become available to you and what you need to do to protect the right to receive it. For additional information about your rights and obligations under the Program and under federal law, you may contact the Plan Administrator or the COBRA Administrator.

One of the Plan Administrators of the Program is the North America Health and Welfare Plans Leader:

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Active Employees: (877) 623-8079
Retired Employees: (800) 344-0661

COBRA continuation coverage for the Program is administered by Towers Watson's BenefitConnect COBRA product (the "COBRA Administrator"):

BenefitConnect COBRA Service Center
P.O. Box 919051
San Diego, CA 92191-9863
(877) 292-6272

9.3 What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the Program when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Child(ren) could become qualified beneficiaries if coverage under the Program is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Program because of either of the following qualifying events:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an active Employee or the Spouse of Record of a Retiree, you become a qualified beneficiary if you lose your coverage under the Program because of any of the following qualifying events:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced (only applicable to Spouses who are Employees working for a Participating Employer);
3. Your Spouse's employment ends for any reason other than his or her gross misconduct (only applicable to Spouses who are Employees working for a Participating Employer);
4. Your Spouse enrolls in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

As explained under *Section 9.2 COBRA Continuation Coverage*, although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners (or for Retirees, Domestic Partners of Record) with comparable protection to Spouses (or Spouses of Record) for the qualifying events described above.

Your Dependent Child(ren) will become qualified beneficiaries if they lose coverage under the Program because of any of the following qualifying events:

1. The parent-Employee or parent-Retiree dies;
2. The parent-Employee's hours of employment are reduced (only applicable to active Employees working for a Participating Employer);
3. The parent-Employee's employment ends for any reason other than his or her gross misconduct (only applicable to active Employees working for a Participating Employer);
4. The parent-Employee or parent-Retiree enrolls in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Program as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of a Retiree, the Retiree is a qualified beneficiary with respect to the bankruptcy. The Retiree's Spouse of Record and Dependent Children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

9.4 When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee or Retiree, commencement of a proceeding in bankruptcy, or the Retiree's enrollment in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of any of these events.

9.5 IMPORTANT: You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation or a Dependent Child's losing eligibility for coverage as a Dependent Child), **you must notify the Plan Administrator within 60 days after the qualifying event occurs**. Except for divorce, you may provide this notice by calling the Plan Administrator at the telephone number provided above. In addition, you must complete and submit the forms described below within the time required. Written notice is required if the qualifying event is divorce. If you are providing written notice, you must send this notice to the Plan Administrator at the address above. In addition, if the qualifying event is divorce, you must provide the following to the Plan Administrator within 60 days of the qualifying event:

- A copy of the page of the divorce decree that specifies the names of the parties of the divorce.
- A copy of the page of the divorce decree that shows the judge's signature and the effective date of the divorce.
- Former Spouse's mailing address.
- Former Spouse's Social Security number.

If your Domestic Partnership ends, you must provide the Plan Administrator with a valid "Termination of Domestic Partner Relationship" form within 60 days of the end of the Domestic Partnership.

If the qualifying event is a Dependent Child's loss of eligibility for coverage under a Plan, you must complete a Change in Status form that may be obtained from the Dow Benefits web site or by requesting one from the HR or Retiree Service Centers. In addition, you must complete a Dependent Qualifying Event letter, which may be obtained by requesting one from the Plan Administrator. You must return these forms to the Plan Administrator within 60 days of the Dependent losing eligibility for coverage.

If these procedures are not followed or if the notice is not provided to the Plan Administrator within the time required, any Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record), or Dependent Child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

9.6 How is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For example, both you and your Spouse (or for Retirees, your Spouse of Record) may elect continuation coverage, or only one of you. You may elect COBRA continuation coverage on behalf of your Spouse (or for Retirees, Spouse of Record), and parents may elect COBRA continuation coverage on behalf of their children.

To elect COBRA continuation coverage, a qualified beneficiary must complete the COBRA Administrator's election form. The completed election form must be provided to the COBRA Administrator within 60 days of being provided a COBRA election notice, at the address provided on the election form and following the procedures specified on the form. If the election form is mailed, it must be postmarked no later than the last day of the 60-day election period. If a qualified beneficiary does not elect continuation coverage within this 60-day election period, the qualified beneficiary WILL LOSE HIS OR HER RIGHT TO ELECT CONTINUATION COVERAGE.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, your enrollment in Medicare (Part A, Part B, or both), your divorce or legal separation, or your Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage may continue for up to a total of 36 months. When the qualifying event is the end of employment or reduction

of your hours of employment, COBRA continuation coverage may continue for up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage may be extended:

Medicare Extension for Spouse and Dependent Children

When the qualifying event is the end of employment or reduction of your hours of employment, and you enrolled in Medicare benefits fewer than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you may continue until 36 months after the date of Medicare enrollment. For example, if you become enrolled in Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your Spouse and Dependent Children may continue up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension of 18-Month Period of Continuation Coverage

When the qualifying event is the end of employment or a reduction of your hours of employment, and you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and you provide written notice to the COBRA Administrator by the time specified below, the qualified beneficiary may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You or the qualified beneficiary must provide written notice and a copy of the written determination of disability from the Social Security Administration to the COBRA Administrator at the address indicated above within 60 days of the date of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. You or the qualified beneficiary may be charged up to 150% of the group rate during the 11-month disability extension. If the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act, you must notify the COBRA Administrator at the address indicated above within 30 days upon the determination that the qualified beneficiary is no longer disabled. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

When the qualifying event is the end of employment or reduction in your hours of employment and your family experiences another qualifying event while receiving COBRA continuation coverage, your Spouse and Dependent Children may receive up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months, provided that notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and Dependent Child(ren) if the former Employee dies, enrolls in Medicare (Part A, Part B, or both) and this causes a loss of coverage under the Program, or gets divorced. The extension may also be available to a Dependent Child when that child stops being eligible under the Program as a Dependent Child. The extension is only available if the event would have caused the Spouse and Dependent Child(ren) to lose coverage under the Program had the first qualifying event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator at the address indicated above. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator within the required period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE.

9.7 Can COBRA Continuation Coverage Terminate Before the End of the Maximum Coverage Period?

Continuation coverage terminates before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions became prohibited beginning in 2014 under the Patient Protection and Affordable Care Act); (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees or retirees. Continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B (or both). The Program reserves the right to retroactively cancel COBRA coverage and in that case will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

9.8 How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage.

First Payment of Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form that you receive from the COBRA Administrator. However, you must make your first payment within 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) **If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights of the Program.**

Your first payment must cover the cost of continuation coverage from the time your coverage under the Program would have otherwise terminated up to through the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Program, these periodic payments for continuation coverage are due on the date indicated on your payment coupons from the COBRA Administrator. If you make a period payment on or before its due date, your coverage under the Program will continue for that coverage period without any break. You must make your payment by the due date or within the grace period (discussed below).

Periodic payments for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Program.

9.9 More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption with the Covered Employee or Retiree during COBRA Period

A child born to, adopted by or placed for adoption with you when you are receiving continuation coverage is considered to be a qualified beneficiary if you are a qualified beneficiary and you have elected continuation coverage for yourself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for your family members. To be enrolled in the Plan, the child must satisfy the otherwise applicable Program eligibility requirements (for example, regarding age).

Alternate Recipients under QMCSOs

A child who is receiving benefits under a Program pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during your period of employment with the employer is entitled to the same rights under COBRA as a Dependent Child, regardless of whether that child would otherwise be considered a Dependent.

9.10 If You Have Questions

Questions about the Program or your COBRA continuation coverage rights should be addressed to the Plan Administrator or the COBRA Administrator. For information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll-free number at 1-888-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit http://www.healthcare.gov.

9.11 Keep the Program Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Section 10. Notices Required By Law

10.1 Expatriate Health Plan

The Plan is considered an expatriate health plan. Under U.S. federal guidance related to health care reform, an expatriate plan is an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage. Accordingly, Plan coverage provided under the Plan is not subject to the coverage mandates and prohibitions and other requirements for group health plans under subtitles A and C of Title I of the Patient Protection and Affordable Care Act, as amended ("PPACA"). The Plan may choose to comply with some or all of these requirements voluntarily.

10.2 Your Legal Rights Under ERISA

As a Participant in the Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This law requires that all Program Participants must be able to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Program, including insurance contracts and collective bargaining agreements (if applicable), the Plan Document, and the latest annual report filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report, the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.
- Continue health care coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents must pay for such coverage. For more information, see *Section 9.2 COBRA Continuation Coverage*.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Preexisting coverage exclusions will not apply to any member under the age of 19.

In addition to creating rights for you and all other Program Participants, ERISA imposes duties on the people who are responsible for operating an employee benefit plan. The people who operate the Program, called "fiduciaries," have a duty to act prudently and in the interest of you and other Participants and beneficiaries.

No one, including your employer, your union (if applicable), or any other person, may discharge you, or otherwise discriminate against you in any way, for pursuing a welfare benefit or for exercising your rights under ERISA.

Enforce your rights: If you have a Claim for Plan Benefits that is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Program fiduciaries misuse the Program's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. In addition, if you disagree with the Program's

decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. For more information regarding enforcing your rights in court, see *Section 12. Litigation*.

Assistance with your questions: If you have any questions about the information in this SPD or an eligibility for coverage question, you should contact the Plan Administrator. If you have a question about the benefits covered, or the terms and conditions for receiving benefits, network providers, etc., you should contact CIGNA. For the contact information for the Plan Administrator and for your Plan, see *Section 1. ERISA Information*. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

10.3 Certificates of Coverage

When your Program coverage ends, Dow will mail you a certificate of coverage stating the dates you were covered under the Program and the type of coverage you had. If you enroll for medical coverage under another employer-sponsored health plan that includes a waiting period, your new employer is required under the Health Insurance Portability and Accountability Act to credit your Program coverage towards the waiting period. If you elect to continue Program coverage under COBRA, when your COBRA coverage ends, you will receive another certificate of coverage from Dow. In addition, if you would like another certificate of coverage, you can request one at any time within the 24-month period after your Dow sponsored Plan coverage ceases by writing to the HR Service Center, The Dow Chemical Company, Employee Development Center, Midland, Michigan, 48674.

You are required to inform Dow of any change in your Dependent's eligibility status as soon as possible, and no later than during the annual enrollment period. Dow will provide a certificate of coverage for your covered Dependents upon request. If Dow knows that coverage for your covered Dependent has terminated, it will provide a certificate of coverage for your covered Dependents.

10.4 Information Exchanged by the Program's Business Associates

Dow and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates. The Company may use aggregate data and summary health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with Dow and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA.

Section 11. Other Important Information

11.1 Plan Administrator's Discretion

The Plan Administrators are the Vice President, Human Resources Center of Expertise; Global Benefits Director; Associate Director of North America Benefits; and North America Health and Welfare Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are

authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 7. Claims Procedures*.

11.2 Plan Document

The Program will be administered in accordance with its terms. If the VPHR determines that the Plan Document has a drafting error (sometimes called a "scrivener's error"), the Plan Document will be applied and interpreted without regard to that error. The determination of whether there is a scrivener's error, and how to apply and interpret the Plan in the event of a scrivener's error, will be made by the VPHR, in the exercise of his best judgment and sole discretion, based on his understanding of Dow's intent in establishing the Plan and taking into account all evidence (written and oral) that he deems appropriate or helpful.

11.3 No Government Guarantee of Welfare Benefits

Welfare benefits, such as the benefits provided by the Program and the Plan, are not required to be guaranteed by a government agency.

11.4 Dow's Right to Terminate or Amend the Plan

The Dow Chemical Company reserves the right to amend, modify or terminate the Program and the Plan, (including amending the Plan Document and the SPDs), at any time, for any reason, in its sole discretion with or without notice, retroactively or prospectively, to the full extent permitted by law. The procedures for amending, modifying and terminating the Program and Plan are set forth in the Plan Document.

If the Company terminates the Plan, the assets of the Plan, if any, shall not be used for the benefit of the Company, but may be used to:

- Provide benefits under the Plan and pay the expenses of administering the Plan; or
- Provide cash for Participants, in accordance with applicable law.

11.5 Fraud Against the Plan

If you intentionally misrepresent information to the Program or Plan; knowingly withhold relevant information from the Program or Plan; or deceive or mislead the Program or Plan; the Plan Administrator may (1) terminate your participation in the Plan, either retroactively to the date deemed appropriate by the Plan Administrator, or prospectively; (2) require you to reimburse the Plan for amounts it paid to you or your Dependents, including all costs of collection such as attorneys' fees and court costs; and/or (3) prohibit you from enrolling in the Program. In addition, your employer may terminate your employment, pursue civil and/or criminal action against you, or take other legal action. If you or your Dependent(s) are terminated from eligibility under any benefit plan sponsored by Dow or a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 12. Litigation and Class Action Lawsuits

12.1 Litigation

If you wish to file a lawsuit against the Program or the Plan (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any

kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures described in *Section 7. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA. (A lawsuit against the Plan is considered a lawsuit against the Program of which the Plan is a part, for purposes of this SPD.)

The Applicable Limitations Period is the period ending one year after:

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the Program or to clarify your right to future benefits under the terms of the Program, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Program first repudiated its alleged obligation to provide such benefits;
2. in the case of a claim or action to enforce an alleged right under the Program (other than a claim or other action to recover Benefits), the date the Program first denied your request to exercise such right; or
3. in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

If a lawsuit is filed on behalf of more than one individual, the Applicable Limitations Period applies separately with respect to each individual.

A Claim for Plan Benefits or an appeal of a complete or partial denial of a Claim, as described in the claims and appeals sections, generally falls under (1) above. Please note, however, that if you have a timely Claim pending before the Initial Claims Reviewer or a timely appeal pending before the Appeals Administrator when the Applicable Limitations Period would otherwise expire, the Applicable Limitations Period will be extended to the date that is 180 calendar days after the Appeals Administrator renders its final decision.

The Applicable Limitations Period replaces and supersedes any limitations period that ends at a later time that otherwise might be deemed applicable under any state or federal law. The Applicable Limitations Period does not extend any limitations period under state or federal law. The VPHR may, in his discretion, extend the Applicable Limitations Period upon a showing of exceptional circumstances, but such an extension is at the sole discretion of the VPHR and is not subject to review.

12.2 Class Action Lawsuits

Legal actions against the Program or the Plan must be filed in U.S. federal court. Class action lawsuits must be filed in either (1) the jurisdiction in which the Program is principally administered (currently the Northern Division of the United States District Court for the Eastern District of Michigan) or (2) the jurisdiction in the United States of America where the largest number of putative members of the class action reside (or, if that jurisdiction cannot be determined, the jurisdiction in which the largest number of class members is reasonably believed to reside).

If any putative class action is filed in a jurisdiction other than one of those described above, or if any non-class action filed in such a jurisdiction is subsequently amended or altered to include class action allegations, then the Program, all parties to such action that are related to the Program (such as a plan fiduciary, administrator or party in interest), and all alleged Participants must take all necessary steps to have the action removed to, transferred to, or re-filed in one of the jurisdictions described above.

This forum selection provision is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations.

This provision does not waive the requirement to exhaust administrative remedies before initiating litigation.

Section 13. Incompetent and Deceased Participants

If the Administrator determines that you or your Dependent is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan the Administrator may make benefit payments to the court-appointed legal guardian for you or your Dependent, to an individual who has become the legal guardian for you or your Dependent by operation of state law, or to another individual whom the Administrator determines is the appropriate person to receive such benefits on behalf of you or your Dependent.

Payments due to deceased Participants from claims made under a Plan shall be made to the Participant's estate.

Section 14. Privilege

If the Company or a Participating Employer (or a person or entity acting on behalf of the Company or a Participating Employer) or an Administrator or other Plan fiduciary (an "Advisee") engages attorneys, accountants, actuaries, consultants, and other service providers (an "Advisor") to advise them on issues related to the Plan or the Advisee's responsibilities under the Plan:

- the Advisor's client is the Advisee and not any Employee, Participant, Dependent, beneficiary, claimant, or other person;
- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and
- no Employee, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his Advisors with respect to whom a privilege applies, unless mandated by a court order.

Section 15. Waivers

A term, condition, or provision of the Program shall not be waived unless the purported waiver is in writing signed by the Plan Administrator. A written waiver shall operate only as the specific term, condition, or provision waived and shall remain in effect only for the period specifically stated in the waiver.

Section 16. Providing Notice to Administrator

No notice, election or communication in connection with the Program that you, a Dependent or other person makes or submits will be effective unless duly executed and filed with the appropriate Administrator (including any of its representatives, agents, or delegates) in the form and manner required by the appropriate Administrator.

Section 17. Funding

Dow and Participating Employers share the premium costs with Participants. Participant contributions are either made through payroll deduction, deducted from pension benefits, or paid separately by the Participant.

Benefits are underwritten by Connecticut General Life Insurance Company (CIGNA). The Program is an insured plan under ERISA.

Any assets of the Program may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.

Section 18. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program or Plan were provided to, or on behalf of, a Participant or other person (for example, because benefits were paid even though the individual did not meet the Program eligibility requirements):

- The amount of any other benefit paid to, or on behalf of, such Participant or other person under the Program may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant or other person to reimburse the Program for benefits paid, including reasonable interest.
- If the person does not reimburse the Program by the date determined by the Plan Administrator, the Plan Administrator may cancel coverage for the Participant and refuse re-enrollment.
- The Plan Administrator may elect recoupment or reimbursement, regardless of whether the person who received the excess benefit was a Participant entitled to receive benefits under the Program, and regardless of whether the excess benefit was provided by reason of the Plan Administrator's error or by reason of false misleading, or inaccurate information furnished by the Participant or any other person.

For excess payments to, or on behalf of, Dependents, the Plan Administrator may elect to pursue any of the above remedies directly against the Employee or Retiree or his estate, as applicable.

Section 19. Tax Consequences of Coverage and Benefits

Neither the Company, nor any Participating Employer or any other affiliate, makes any assertion or warranty about (1) health care services and supplies that a Participant obtains, or obtains reimbursement for, as Plan benefits; or (2) the tax treatment of Plan coverage benefits. You or your Dependents shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

Section 20. No Assignment of Benefits

In general, except to the extent required by law or otherwise provided in the Plan Document, an Incorporated Document, or the SPD, benefits payable under the Program shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or change of any kind. You may direct that benefits payable to you be paid instead to a provider or to a person who has agreed to pay for any benefits payable under the Program. The Program reserves the right to make payment directly to you, however.

Section 21. Definitions

The following are some of the defined terms of the Program. Additional terms are defined in the Plan Document for the Program and the materials provided by Cigna describing the benefits it provides. A

copy of the Plan Document is available upon request of the Plan Administrator at the contact information provided in *Section 1. ERISA Information.*

Administrator
Either the Claims Administrator or the Plan Administrator.

Appeals Administrator
The Appeals Administrator with respect to reviewing an adverse Claim for Benefit is CIGNA. The Appeals Administrators with respect to reviewing an adverse Claim for an Eligibility Determination are the Global Benefits Director and the Associate Director North America Benefits.

Bargained-for Employee
An Employee who is represented by a collective bargaining unit that is recognized by the Company or Participating Employer.

Certificate of Insurance
The insurance certificate issued by CIGNA. You may request a copy from CIGNA or the Plan Administrator.

CIGNA
Connecticut General Life Insurance Company

Claim
A written request by a claimant for a Plan benefit under or for an eligibility determination that contains, at a minimum, the information described in *Section 7. Claims Procedures*.

Claim for Eligibility Determination
A Claim requesting a determination as to whether a claimant is eligible to be a Participant under the Plan or Program or as to the amount a claimant must contribute towards the cost of coverage.

Claim for Plan Benefits
A Claim requesting that the Plan pay for benefits covered under the Plan.

Claims Administrator
Either the Initial Claims Reviewer or the Appeals Administrator, depending on the context of the sentence in which the term is used.

COBRA
The federal law (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) that allows a Participant to stay enrolled in the Program for a limited time after coverage for that person would ordinarily cease.

Code
The Internal Revenue Code of 1986, as amended.

Company
The Dow Chemical Company.

Creditable Coverage
With respect to HIPAA, coverage under the Plan, Medicare, Medicaid, or any other group health, individual health or other health insurance coverage described in 29 CFR § 2590.701-4.

Dependent
An Employee's Spouse, Domestic Partner, Dependent Child(ren), or a child to whom a Qualified Medical Support Order applies; or a Retiree's Spouse of Record, Domestic Partner of Record, or Dependent Child(ren), or a child to whom a Qualified Medical Support Order applies.

Dependent Child

A "Dependent Child" is a child who must be:

- Your birth or legally adopted child; or
- Your Spouse's or Domestic Partner's natural or adopted child (or, for Retirees, must be your Spouse or Record or Domestic Partner of Record's natural or adopted child); or
- A child for whom you or your Spouse/Domestic Partner (for Retirees, your Spouse of Record/Domestic Partner of Record) have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently "legally relinquished all of their parental rights" in a court of law. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:
  - authority to consent to the child's Marriage or adoption, or
  - authority to enlist the child in the armed forces of the U.S.;
  - right to the child's services and earnings; and
  - power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

In addition to meeting the above requirements, in order to be eligible for coverage, the "Dependent Child" must not be excluded for one of the reasons described in *Dependent Child(ren) Exclusions* under Section 2.3 of this SPD.

If you are a Retiree, you may cover a child of your Spouse/Domestic Partner who is not your Spouse of Record/Domestic Partner of Record only if the child (1) is also your birth or adopted child (or a child for whom you are the legal guardian) (as explained above) or (2) was covered as your Dependent under Dow retiree medical coverage prior to March 1, 2013 and remains continuously covered under Dow retiree medical coverage.

Domestic Partner

A person who is a member of a "Domestic Partnership". A "Domestic Partnership" means a relationship between two people that meets all of the requirements of paragraph a, or both of the requirements of paragraph b:

a. Requirements of paragraph a (Facts and Circumstances Test):

1. the two people have lived together for at least twelve (12) consecutive months immediately prior to receiving coverage under the Program,
2. the two people are not Married to other persons and were not Married to other persons at any time during the twelve (12) consecutive month period preceding coverage under the Program,
3. the two people are and were, during the twelve (12) consecutive month period preceding coverage under the Program, each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely,
4. both people are legally competent and able to enter into a contract,
5. the two people are not related to each other in a way which would prohibit legal Marriage,
6. in entering the relationship with each other, neither of the two people is acting fraudulently or under duress,

7. during the twelve (12) month period preceding coverage under the Program, the two people have been and are financially interdependent with each other, and
8. both people signed a statement acceptable to the Plan Administrator indicating the above requirements have been met and provided it to the Plan Administrator.

b. Requirements of paragraph b (Civil Union Test):

1. evidence satisfactory to the Plan Administrator is provided that the two people are registered as domestic partners, or partners in a civil union in a state or municipality or country that legally recognizes such domestic partnerships or civil unions, and
2. both people signed a statement acceptable to the Plan Administrator and provided it to the Plan Administrator.

Domestic Partner of Record

With regard to a Retiree--

- who was eligible for coverage under the Program before January 1, 2003: a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Retiree Medical Care Program on December 31, 2002, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to December 31, 2002.); or
- who became eligible for coverage under the Program on or after January 1, 2003: a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.)

With regard to a Participant who dies while an active Employee, "Domestic Partner of Record" means the Domestic Partner of such Participant, if any, as of the date of the Participant's death.

Dow

A Participating Employer, or collectively, the Participating Employers, as determined by the context in which it is used. "Dow" and "Participating Employers" have the same meaning and are used interchangeably.

Employee

A person who:

- is employed by a Participating Employer to perform personal services in an employer-employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute;
- receives a payment for services performed for the Participating Employer directly from a Participating Employer's U.S. Payroll Department,
- if not a U.S. citizen or a U.S. resident alien, is Localized in the U.S.; and
- if on international assignment, is either a U.S. citizen or Localized in the U.S.

The definition of "Employee" does not include an individual who is determined by the Plan Administrator (or a Participating Employer) to be:

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement between the Participating Employer and another business, such as a leasing organization;
2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;
3. an individual whom is classified or treated as an independent contractor; or
4. a self-employed individual, as defined in Code § 401(c)(1)(A), which generally means an individual who has net earnings from self-employment in a trade or business in which the personal services of the individual are a material income-producing factor.

If the Plan Administrator (or a Participating Employer) determines that you are not an "Employee," you will not be eligible to participate in the Program, regardless of whether the determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters or whether you are subsequently treated or classified as an Employee for certain specified purposes. Any change to your status by reason of reclassification or subsequent treatment will apply prospectively only (*i.e.,* will apply to costs that are incurred and eligible for reimbursement under the terms of the Program, after your reclassification).

ERISA
Employee Retirement Income Security Act of 1974, as amended.

Full-Time
Classified by Dow or a Participating Employer as having Full-Time status.

HIPAA
The Health Insurance Portability and Accountability Act of 1996.

Initial Claims Reviewer
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is CIGNA. The Initial Claims Reviewer with respect to deciding a Claim for Eligibility Determination is the North America Health and Welfare Plans Leader.

Less-than-Full-Time Employee
An Employee who has been approved by the Participating Employer to work 20 to 39 hours/week and is classified by the Participating Employer as having "Less-Than-Full-Time Status."

Localized
A person is "Localized" when an individual has been determined by a Participating Employer to be permanently relocated to a particular country, and the individual has accepted such determination. For example, an Employee who is a Malaysian national is "Localized" to the U.S. when a Participating Employer has determined that such Employee is permanently relocated to the U.S., and such Employee has accepted such determination.

Married or Marriage
A civil contract between two individuals who have the legal capacity to marry and that is formalized by a marriage license. Whether a person is "Married" for purposes of the Program shall be determined in accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue Service and the Department of Labor. For periods before September 16, 2013, an individual shall be

treated as Married only to the extent provided in the provisions of the Program then in effect. The Program does not recognize common law marriages except that:

1. If an Employee was a participant of a plan of The Dow Chemical Company Medical Care Program before November 1, 1993, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a Dow Medical Plan before November 1, 1993, then such common law Spouse is deemed under the Program to be Married to the Employee;
2. Effective January 1, 1996, the Program recognizes a marriage that meets the requirement of Texas Family Code Annotated section 2.402; and
3. Effective January 1, 2002, common law Spouses of UCC employees and former UCC employees who were covered under a UCC medical plan at any time between February 5, 2001, and December 31, 2001, as "spouses" of UCC employees will be deemed to be "Married" for purposes of the Program.

Medicare
The "Health Insurance for the Aged and Disabled" provisions of the Social Security Act, as amended.

Participant
An Employee, Retiree, Dependent or such other individual who meets the eligibility criteria of the Program, elects to participate in the Program, and remains eligible for benefits under the Program.

Participating Employer
The Company or one of its subsidiaries or affiliates that has accepted an international relocation of an Employee of the Company or one of its subsidiaries or affiliates coordinated by the Company's International Relocations Department. "Participating Employers" and "Dow" have the same meaning and are used interchangeably. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan
International Medical and Dental Plan of The Dow Chemical Company Insured Health Program.

Plan Administrator
Each of the Vice President, Human Resources Center of Expertise; the Global Benefits Director; the Associate Director of North America Benefits; the North America Health and Welfare Plans Leader; and such other person, group of persons or entity which may be designated by The Dow Chemical Company in accordance with the Plan Document.

Plan Document
The plan document for the Program, which is ERISA Plan #601. The summary plan description for the Plan is an integral part of the Plan Document.

Program
The Dow Chemical Company Insured Health Program.

QMSCO
A QMCSO is a "Qualified Medical Child Support Order." This is a court order that gives a child the right to be covered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent. You can obtain a free copy of the Program's QMCSO procedures, which explain how the Program determines whether a court order meets the Program's requirements by requesting a copy from the Plan Administrator.

Regular Employee
An Employee who is classified by the Employer as "regular."

"Retire" or "Retirement"
"Retire" or "Retirement" means when an Employee becomes a Retiree.

Retiree
"Retiree" within the meaning of the Plan Document, which generally means a former Employee who meets either of the following requirements:

a. The former Employee was age 50 or older and had at least 10 years of Service at the time his employment terminated with a Dow Entity, is a "retiree" under the terms of the Dow Employees' Pension Plan on the day immediately preceding termination of employment, and has a vested benefit under the DEPP component of the Dow Employees' Pension Plan; or

b. The former Employee has been Localized in the U.S. and:

   1. is still a Localized U.S. Employee when his employment with a Dow Entity ends;
   2. is age 50 or older with 10 or more years of Service when his employment with a Dow Entity ends;
   3. either
      i. at the time he was Localized in the U.S., he was eligible to participate in the DEPP component, although he need not participate in or be vested in the Dow Employees' Pension Plan at the time his employment ends; or
      ii. his hire date at a Dow subsidiary was prior to January 1, 2008, he was Localized in the U.S. between January 1, 2008 and September 1, 2009, and he is a vested participant in the PPA component of the Dow Employees' Pension Plan; and
   4. at the time his employment with the Dow Entity ends, he is not immediately transferred to an 80% or more owned Dow subsidiary or affiliate.

However, a former Employee is not a Retiree under the Program if his pension assets in the Dow Employees' Pension Plan were transferred to another pension plan (and therefore he is not considered "retired" under the terms of the Dow Employees' Pension Plan), even if he has reached age 50 and has 10 or more years of Service at the time his employment with the Dow Entity ends.

Salaried
Not represented by a collective bargaining unit.

Service
"Service" means, except for Retirees who have been Localized in the U.S., and except as otherwise specifically provided in the Plan Document:

a. For a former Employee who was hired on or after January 1, 1993, but before January 1, 2008, by a subsidiary or affiliate of the Company that was 80% or more owned by the Company at the time such Employee was hired by such subsidiary or affiliate, "Service" means "credited service" recognized by the Dow Employees' Pension Plan (if any).

b. For a former Employee who was hired before January 1, 1993, by a subsidiary or affiliate of the Company that was 80% or more owned by the Company at the time the Employee was hired by such subsidiary or affiliate, "Service" means the greater of "credited service" or "eligibility service" recognized by the Dow Employees' Pension Plan (if any).

For purposes of calculating "Service" and whether a hire date is on or after January 1, 1993, the following rules apply:

- For an employee of an entity acquired by the Company, the Program deems the hire date to be the later of (1) the date the entity became a Participating Employer under the Program, or (2) the employee's hire date at such entity.
- For an employee of an entity acquired by the Company that does not become a Participating Employer under the Program, and the employee is subsequently hired by the Company, the hire date shall be the date the Company hired such employee.
- For a former Employee who is rehired--
  - If the Employee is a participant in the DEPP component of the Dow Employees' Pension Plan on the date of re-hire, the Program recognizes the first hire-date to determine whether eligibility or credited service is applicable and to determine how much Service will be recognized by the Program.
  - If the Employee is not a participant of the DEPP component of the Dow Employees' Pension Plan on the date of re-hire, the Program recognizes the first hire-date to determine whether eligibility or credited service (as recognized by the Dow Employees' Pension Plan) is applicable, and to determine how much Service will be recognized by the Program *if (and only if)* (1) on the date employment terminated with Dow, the employee was eligible for coverage under the Program as a Retiree, 60 or 65 Point Retiree Medical Severance Plan Participant; (2) the Employee was subsequently rehired by Dow; and (3) after rehire, the Employee became a participant in the Personal Pension Account component of the Dow Employees' Pension Plan.

For Retirees who have been Localized in the U.S.:

- Only for purposes of determining eligibility, "Service" means the period(s) of time that the Retiree worked for the Company or any affiliate or subsidiary owned 80% or more by the Company.
- For purposes of determining whether the hire date was on or after January 1, 1993, the Program recognizes hire dates and periods of employment with subsidiaries and affiliates that provide subsidized retiree medical coverage for their employees in an amount comparable to the Company's subsidization of the Program, and with subsidiaries and affiliates that are located in countries whose governments provide coverage comparable to the Program's coverage to such subsidiaries and affiliates' retirees.

For purposes of the Retiree Support Schedule, "Service" includes the period(s) of time that the Retiree worked for a 50% or more owned subsidiary or affiliate of the Company only if, during such period(s), such subsidiary or affiliate subsidized retiree medical coverage for its employees in an amount comparable to the Company's subsidization of the Program; or, such subsidiary or affiliate was located in a country whose government provides coverage comparable to the Program's coverage to such subsidiary or affiliate's retirees.

Special provisions regarding the definition of "Service" may apply in certain merger, acquisition, joint ventures and other special circumstances. For details, particularly if you were part of a merger or acquisition, contact the Retiree Service Center or refer to the Plan Document.

Spouse

A person who is Married to the Employee. See the definition of Marriage for further details. With regard to a Retiree, your Spouse must be your Spouse of Record in order to be eligible for coverage under the Program.

Spouse of Record

With regard to a Retiree (or other Participant eligible for coverage under Section 3.3 of this SPD)--

- who was eligible for coverage under the Program before January 1, 2003: the person who was Married to the former Employee on December 31, 2002, and continues to be Married to the former Employee; or
- who became eligible for coverage under the Program on or after January 1, 2003: the person who was Married to the former Employee on his or her last day on the payroll, and continues to be Married to the former Employee.

With regard to a Participant who dies while an active Employee, "Spouse of Record" means the Spouse of such Participant (if any) as of the date of the Participant's death.

With regard to a Participant who Retires with a Domestic Partner of Record and is later Married to the Domestic Partner of Record, "Spouse of Record" means the Participant's former Domestic Partner of Record.

Summary Plan Description ("SPD")

The summary plan description for the Plan. The SPD is an integral part of the Plan Document.

Termination of Domestic Partnership

In order to meet the definition of "Termination of Domestic Partnership," you must complete and sign a statement satisfactory to the Plan Administrator that states, among other things, that the Domestic Partnership is terminated. A Termination of Domestic Partnership is not effective with respect to the Program until the signed statement has been received by the Plan Administrator.

VPHR

The Vice President of the Company with senior responsibility for human resources.

Section 22. For More Information

For more information regarding the provisions in this SPD, please contact the Dow HR Services Center (if you are an Employee) or the Retiree Service Center (if you are a Retiree) using the contact information in *Section 1. ERISA Information*.

IMPORTANT NOTE

This booklet is the Summary Plan Description ("SPD") for the International Medical and Dental Plan offered under The Dow Chemical Company Insured Health Program (the "Program"). However, this SPD is not all-inclusive and it is not intended to take the place of the Program's legal documents.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (including any the Plan) at any time in its sole discretion.

The Plan Document can be made available for your review upon written request to the Plan Administrator (whose contact information is listed in *Section 1. ERISA Information*). The SPD and the Program do not constitute a contract of employment. Your employer retains the right to terminate your employment or otherwise deal with your employment as if this SPD and the Program had never existed.

Appendix A Important Notice of Creditable Coverage For Medicare-Eligibles

Applicable to Plan Year 2014

The International Medical and Dental Plan *does* provide *Creditable* Coverage for prescription drugs.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Dow Chemical Company ("Dow") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Dow has determined that the prescription drug coverage offered by the Plans listed above is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dow coverage will be affected. If you enroll in Medicare prescription drug coverage (other than a Medicare Advantage-PD Plan offered through The Dow Chemical Company Insured Health Program), you will be disqualified from participation in any retiree medical and prescription coverage sponsored by Dow while you are enrolled in the Medicare prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Dow coverage, be aware that you and your dependents will be able to enroll in the Program during Dow's annual enrollment period; provided that you are eligible for coverage under the Program post-Medicare eligibility.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Dow and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Retiree Service Center at (800) 344-0661. **NOTE:** You'll get this notice each year. You also may request a copy of this notice at any time. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dow changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	Fall, 2013
Name of Entity/Sender:	The Dow Chemical Company
Contact--Position/Office:	U.S. Benefits Center
Address:	Employee Development Center Midland, MI 48674
Phone Number:	(800)-344-0661

Appendix B CHIP Premium Assistance Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid</td></tr>
<tr><td></td><td>Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565