Summary Plan Description for:

The Dow Chemical Company
Health Care Reimbursement Account Plan

Amended and Restated

Effective January 1, 2017 and thereafter until superseded

This Summary Plan Description (SPD) supersedes all prior SPDs.

Copies of updated SPDs (including this SPD) are available at the Dow Family Health website (http://www.dowfamilyhealth.com) or by requesting a copy from the HR Service Center by calling 877-623-8079 or by submitting your request through the Dow Benefits website's Message Center available at (http://dowbenefits.ehr.com).

Summaries of material modifications may also be published from time to time in separate documents.

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The Dow Chemical Company
Health Care Reimbursement Account Plan

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The Health Care Reimbursement Account Plan

Overview

This is the Summary Plan Description ("SPD") for The Dow Chemical Company Health Care Reimbursement Account Plan (the "Plan"), which is a component plan of The Dow Chemical Company Flexible Spending Plan (the "Dow Flexible Spending Plan"). The Plan is designed to help you save tax dollars. It allows you to set aside part of your salary in pre-tax dollars for you to draw on throughout the year to meet certain expenses. Part of your salary can be directed into a Health Care Reimbursement Account ("HCRA") or Limited Use HCRA (also referred to as a Limited Use Flexible Spending Account). Based on your needs, and those of your family, you may consider participating in this Plan.

The Plan has been designed according to current tax law. Changes in the law may affect provisions of the Plan.

Answers to your questions about the Plan can be found in this SPD. The Plan is governed by the plan document for the Dow Flexible Spending Plan. 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.

Words that are capitalized are either defined in this SPD or in the Plan Document for the Plan. The Plan Document is available upon request of the Plan Administrator (identified under *ERISA Information*).

The Company reserves the right to amend, modify and terminate the Plan at any time in its sole discretion.

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

For additional information about the Plan, check the Dow Intranet or contact Aetna Inc. or the HR Service Center at (877) 623-8079.

The Health Care Reimbursement Account Plan

Purpose and Highlights of the Plan

The Plan allows you to use pre-tax dollars to pay for eligible medical and dental expenses incurred by you, your Spouse, or anyone you claim as a Dependent on your federal income tax return. The Plan reimburses you for expenses that are *not covered* by your medical or dental plans or by any other source. When expenses are incurred, you submit them to the Claims Administrator for reimbursement. In general:

- You are eligible to make pre-tax deposits for health care expenses if you are an active, Regular, Full-Time or Less-Than-Full-Time Salaried Employee or an active, Regular, Full-Time Bargained-for Employee whose collective bargaining agreement provides for your participation.
- You may enroll during the annual enrollment period, or within 90 days of beginning work or experiencing a qualifying change in status (180 days for geographic transfer) through the Dow Benefits web site or by calling the HR Service Center.
- You may make deposits to a HCRA or Limited Use HCRA (your "Account") totaling $100 to $2,550 each year for reimbursement of qualified health care expenses.
- You should determine the amount of your pre-tax deposits by estimating your health care expenses for the year.
- If you participate, you are reimbursed from your Account throughout the year when you submit expenses to the Claims Administrator.

Eligibility

All active, Regular, Full-Time and Less-Than-Full-Time Salaried Employees of Participating Employers are eligible to participate in the Plan. Any such Employees who are on a medical or family leave approved by a Participating Employer are eligible, as governed by the terms of the applicable Dow leave policy. Except as otherwise provided in the applicable collective bargaining agreement, active, Regular, Full-Time Bargained-for Employees whose collective bargaining unit and the Participating Employer have agreed to this benefit are eligible to participate. If the terms of the collective bargaining agreement specifically address which Employees are eligible or not eligible for this Plan, then the terms such collective bargaining agreement shall govern as to whether an Employee is eligible.

The applicable Claims Administrator determines eligibility. The Claims Administrator is a fiduciary of the Plan and has the full discretion to interpret the eligibility 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 for Eligibility Determinations are final and binding on Participants. If you would like the applicable Claims Administrator to determine whether you are eligible for participation, you can file a Claim for an Eligibility Determination. See *APPENDIX I: CLAIMS PROCEDURES APPENDIX*.

Eligibility for benefits under the Plan may continue during certain 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 Plan shall be administered consistent with the terms of such approved leaves of absences.

Enrollment

When You May Enroll

If you are eligible to participate in the Plan, you may enroll in the Plan within 90 days of your date of hire, during annual open enrollment, or upon experiencing a "qualifying change in status" event. *You must reenroll each year in order to continue your participation in the Plan.*

- ***New Employment***. New Employees may enroll in the Plan within the first 90 days of employment.

- ***Annual Enrollment***. You may enroll in the Plan for the upcoming calendar year during the annual open enrollment period. Enrollment is typically held during the last quarter of the year and is handled electronically. After the enrollment period has ended, you may not change or make new selections until the next enrollment period unless you have a qualifying change in status.

- ***Qualifying Change in Status***. Employees who have a qualifying change in status that meets the Plan's requirements (such as the birth of a child) may enroll within 90 days of

the status change (180 days for a geographic transfer). Changes in deduction amounts will occur on the first paycheck following the effective date of your change. Please note that if you are decreasing the amount you are contributing, monies already contributed cannot be refunded except through reimbursement of qualified expenses. See *Reimbursement of Qualified Expenses*.

The Accounts in Which You May Enroll

Two types of Accounts are available under the Plan: The Health Care Reimbursement Account ("HCRA") and the Limited Use Health Care Reimbursement Account ("Limited Use HCRA"). Only the Limited Use HCRA is compatible with a health savings account ("HSA"), meaning that if you contribute to an HSA you may not contribute to the HCRA. Accordingly, the following default rules will apply:

- If you are not enrolled in the MAP Plus Option 2 High Deductible Plan but are enrolled in other Dow medical coverage and you elect to participate in this Plan, you will be enrolled in the HCRA.

- If you enroll in the MAP Plus Option 2 High Deductible Plan and you elect to participate in the Plan, you will be enrolled in the Limited Use HCRA (so that you can also simultaneously participate in an HSA). If you want to be enrolled in HCRA, contact Aetna Inc. or the HR Service Center at (877) 623-8079 before the enrollment deadline passes.

- If you are not enrolled in any Dow medical coverage and you elect to participate in this Plan, you will be enrolled in the HCRA. If you want to be enrolled in the Limited Use HCRA, contact Aetna Inc. or the HR Service Center at (877) 623-8079 before the enrollment deadline passes.

You may use amounts deposited to either the HCRA or the Limited Use HCRA to reimburse eligible expenses (described below under *Reimbursement of Qualified Expenses*). However, if you are enrolled in the Limited Use HCRA, you cannot use your Account to reimburse medical and pharmacy expenses before you meet your deductible under the MAP Plus Option 2 High Deductible Plan (or other high deductible health plan).

Deposits To Your Account

Payroll Deductions

Your contributions to your Account are made through pre-tax payroll deductions as authorized by your enrollment. The deductions are made *before* you pay federal, Social Security and, usually, state and local income taxes. You must determine your total deposits for the calendar year when you enroll. For more details, please refer to the latest annual enrollment information.

If you are on a leave of absence approved by the Participating Employer that allows you to continue participating in the Plan, the Plan Administrator has the full discretion to make special administrative arrangements as are necessary, such as suspending your contributions on a

temporary basis during the leave of absence, and requiring you to contribute make-up deposits when you return to work, or any other arrangements that are permitted under applicable law that the Plan Administrator deems appropriate.

Note: Pre-tax deposits may reduce the Social Security benefit you are eligible for from the government because the pre-tax deposits are not included in your earnings used to calculate your Social Security benefit.

Deposit Amounts

You may elect to deposit from $100 to $2,550 each year. If your Spouse participates in the Plan as an eligible Employee or in a health flexible spending arrangement offered by his or her employer, you may each contribute up to $2,550 to each of your accounts.

Changing Deposit Amounts

Your deposits into the Plan are made with pre-tax dollars through the Dow Flexible Spending Plan, a plan intended to qualify under Section 125 of the Internal Revenue Code (the "Code") as a "cafeteria plan." You may change the amount of your deposits only during annual enrollment, or if you have a "qualifying change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan).

This section of the SPD describes the definition of "qualifying change in status," the "consistency rules," and the exceptions to these rules, as well as documentation required to change deposit amounts, deadlines for making these changes, and the Plan's authority to reduce benefit elections of certain Participants.

Any change or termination of your election for your Account may not result in reducing your election to an amount that is less than the amount by which your Account is debited for qualified expenses incurred during the period prior to the effective date of your changed or terminated election. If your new, changed, or terminated election does not meet these requirements, it will be automatically adjusted so that your new election will equal the amount by which your Account has been debited for qualified expenses as of the effective date of the new election.

Qualifying Change in Status

For purposes of the Dow Flexible Spending Plan, a "*qualifying change in status*" is an event listed in one of the bullets below:

- An event that changes your legal marital status, including Marriage, death of Spouse, divorce, or annulment;
- An event that changes your number of Dependents, including birth, adoption, placement for adoption, or death of your Dependent;
- A termination or commencement of employment for you or your Spouse or Dependent;

- A reduction or increase in hours of employment for you, your Spouse, or Dependent ;
- Your Dependent satisfies or ceases to satisfy the requirements for Dependents;
- A change in the place of residence or work for you, your Spouse, or your Dependent;
- Your Spouse gains eligibility for coverage under his or her employer's health plan.

Consistency Rule

In addition to having a "qualifying change in status," you must also meet both of the following consistency rules:

1. The qualifying change in status **must result** in you, your Spouse, or your Dependent **gaining or losing eligibility** for coverage under either the Plan or the parallel plan of your Spouse or Dependent's employer, and

2. The **election change** to the Plan **must correspond** with that gain or loss of coverage.

Example of Application of the Consistency Rule. Mary is a full-time Dow employee. For the Plan Year beginning January 1, 2017, she signs up for the HCRA and decides to put $200 per month into her Account. In February, she changes to Less-Than-Full-Time status. Although under the IRS regulations she has a "qualifying change in status," she does not meet the loss or gain of eligibility for coverage requirement. Therefore, she must continue to contribute $200 per month to her Account. If she is not able to use the amounts contributed to her Account during the year, she will forfeit any excess.

Exceptions to the Qualifying Change in Status and Consistency Rules

You may change the amount of your deposits mid-year without having met the "qualifying 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 ("QMCSO"), requires a change in your election to the medical or dental plans. (You may obtain a free copy of the Plan's QMCSO procedures, which explains how the Plan determines whether a court order meets the Plan's requirements, by requesting a copy from the Plan Administrator at the address or telephone number listed in *ERISA Information*.)

- *Entitlement to Medicare or Medicaid.* If you, your Spouse, or your Dependent becomes entitled to coverage (i.e., enrolled) for Medicare or Medicaid mid-year, (other than for coverage consisting solely for distribution of pediatric vaccines), you may cancel your election to participate in the Plan.

Documentation Required to Make an Election Change

Documentation is required within 90 days (180 days for geographic relocation under the Participating Employer's relocation policy) to show proof of eligibility to make an election change. Required documentation may include birth certificates, passports, Marriage certificates, evidence of loss of Spouse 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. FAILURE TO PROVIDE PROOF OF ELIGIBILITY WITHIN THE TIME REQUIRED WILL RESULT IN NO COVERAGE, AND MAY RESULT IN RETROACTIVE CANCELLATION OF COVERAGE AND FORFEITURE OF AMOUNTS ALREADY CONTRIBUTED TO THE PLAN.

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 update your enrollment information within 90 days of the qualifying change in status event.

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

- For the birth of a child, the date of birth.
- For 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 qualifying change in status event, the effective date of the mid-year election change will be the date of qualifying change in status event.
    - If the Plan Administrator receives your enrollment request on day 32 through 90 after the qualifying change in status event, the effective date of the mid-year election change will be the Plan Administrator's processing date.

Note: Any increase in your deposit amount will be applied only to the expenses incurred after the effective date of the mid-year election change. If you decrease your deposit amount, monies already contributed cannot be refunded except through reimbursement of qualified expenses.

Reduction of Certain Elections to Prevent Discrimination

The Plan Administrator has the unilateral authority to reduce the benefit elections of certain Participants if such a reduction is necessary to prevent the Plan from becoming discriminatory within the meaning of Section 125(b) of the Code. If the Plan Administrator determines, 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 (as defined in the Dow Flexible Spending Plan), 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.

Reimbursement of Qualified Expenses

In general, you may use your Account to reimburse the same types of expenses that qualify as deductions for medical expenses on your federal income tax return. To be eligible for reimbursement from your Account, the expenses must not be eligible for reimbursement by your medical or dental plans or by any other source. Expenses must be incurred on or after the date of your enrollment in the Plan.

Your expenses will be reimbursable after the service was incurred, not when you pay for the service. For example, for orthodontic services, your expenses will be eligible to be reimbursed when the service is incurred, even if you pay for all of the services upfront when the services begin.

You may request reimbursement for eligible expenses incurred by your Spouse and Dependents even if they do not have Dow medical or dental plan coverage, as long as the expenses are not eligible for reimbursement from a medical or dental plan or any other source.

If you are enrolled in the Limited Use HCRA, you may use it to reimburse qualified dental, vision, and preventive care expenses incurred any time on or after you enroll in the Plan; however, you may not use your Account to reimburse medical or prescription drug expenses (other than qualified preventive care expenses) before you meet your deductible under the MAP Plus Option 2 High Deductible Plan (or other high deductible health plan). Once you meet your deductible under the MAP Plus Option 2 High Deductible Plan (or other high deductible health plan), you may use your Limited Use HCRA to reimburse any expenses that may be reimbursed under the HCRA, including medical or prescription drug expenses that are not for preventive care.

Examples of eligible medical and dental expenses include:

- Routine physicals that are not covered by your medical plan.
- Eye examinations, glasses, and contact lenses and supplies.
- Hearing aids.
- Medical and dental plan deductibles and co-payments.
- Expenses that exceed medical and dental plan limits.

- The medical portion of nursing home expenses.

Examples of expenses that are *not* eligible include:

- Insurance premiums.
- Health-related home improvements such as swimming pools or air conditioners.
- Health club dues and/or memberships.
- Cosmetic surgery or procedures that are not medically necessary including hair removal or replacement.
- Over-the-counter medicines, other than insulin, for which you do not have a prescription.

Internal Revenue Service Publication No. 969 includes additional examples of qualified and unqualified expenses. Please contact Aetna if you have any questions regarding expenses that are eligible for reimbursement under the Plan.

If You Leave Dow

If you leave Dow, retire, or transfer to an employer that does not participate in the Plan, you may use money already deposited for expenses incurred for services rendered **prior** to the date you left Dow, retired, or transferred to an ineligible employee group. Your Claim for reimbursement must be received by the Claims Administrator on or before April 30th after the end of the Plan Year. Please see *APPENDIX I: CLAIMS PROCEDURES APPENDIX* for more information about how to submit Claims.

In order to keep coverage through the end of the Plan Year, you may request to deduct a lump-sum from your last paycheck, your accrued vacation payment, or severance pay using pre-tax dollars, equal to an amount sufficient to fulfill the remainder of your annual election.[1] Your request must be made and submitted to Payroll prior to the last paycheck, vacation payment or severance payment sufficient to cover the remainder of your annual election being issued, and you must waive your COBRA rights under the Plan. Your request will not be processed if the amount remaining to be paid to you is less than the remainder of your annual election. Your Claim for reimbursement must be received by the Claims Administrator on or before April 30th of the next Plan Year to file claims for expenses incurred for services rendered through the end of the current Plan Year or through a grace period that extends until March 15th of the next year.

Under COBRA, if you have not used all of the money you have contributed to your Account as of the date you leave Dow, you may elect to continue to contribute the remaining balance due using post-tax dollars at 102% of your contribution amounts. Your Claim for reimbursement

[1] Deductions from accrued vacation payments and severance pay are permissible on or after March 1, 2013.

must be received by the Claims Administrator on or before April 30th of the next plan year to file claims for expenses incurred for services rendered through the end of the plan year or during a grace period that extends until March 15th of the next year. For more information, see *COBRA Continuation Coverage*.

Automatic Roll-over Feature for Network Pharmacy Expenses – For Participants in Dow MAP Plus Option 1 Low Deductible Plan

If you enroll in the Dow MAP Plus Option 1 Low Deductible Plan (the "Option 1 Low Deductible Plan") and/or the a Delta Dental of Michigan Dental Plan, and you elect the "automatic roll-over" feature during annual enrollment, Aetna and Delta will automatically submit for reimbursement under the Plans the portion of any claims that are not covered by the Option 1 Low Deductible Plan or Delta Dental Plan that you incur under the Option 1 Low Deductible Plan or Delta Dental Plan. You benefit by not having to file a Claim for Reimbursement under the Plan and by having your reimbursement automatically sent to you or directly deposited into your bank account. In addition, amounts payable toward your deductible under the Option 1 Low Deductible Plan will be automatically deducted from your Account.

The automatic roll-over feature will be triggered only if you have a positive Account balance.

The automatic roll-over feature is not available to you if:

- You or your covered Dependent have coverage through another medical plan and you coordinate coverage with that plan;
- You cover a Domestic Partner under your medical plan;
- Your Spouse works for Dow, and you are covered under your Spouse's Dow medical plan; or
- You are not enrolled in the Option 1 Low Deductible Plan (*e.g.*, if you are enrolled in the MAP Plus Option 2 High Deductible Plan).

Effect of HCRA on Health Savings Accounts

If you have a remaining balance in your HCRA (not a Limited Use HCRA) at the end of a Plan Year, and you elected during annual enrollment to participate in the MAP Plus Option 2 High Deductible Plan for the upcoming Plan Year, you will not be permitted to begin contributions to your Health Savings Account as of January 1st. In order to make contributions as of January 1st of the upcoming year, you must bring your HCRA balance to zero by December 31st of the current year. Please contact Aetna for information regarding the date by which you must submit your Claims for Plan Benefits in order to bring your HCRA balance to zero by this date. If you delay in submitting your qualified medical expenses, you may not begin making contributions to your Health Savings Account until April 1st of the upcoming year. For example, if you do not bring your HCRA balance to zero by December 31, 2017, you may not begin making contributions to your Health Savings Account until April 1, 2018.

Forfeitures

Any balance from the previous year that remains in your Account after the deadline for incurring and submitting claims must be forfeited. The Plan may have "experience gains" when the premiums (*i.e.*, deposits) it receives from individual Participants exceeds their reimbursements for the Plan Year. Experience gains may be retained by the Company or used in any of the following ways, at the Plan Administrator's discretion:

- Defray reasonable administrative costs of the Plan.
- Increase coverage amount to Participants.
- Provide Participants with experience gains in the form of cash.

If the Plan Administrator decides to use experience gains to increase the coverage amount to Participants, the maximum annual amount that a Participant may elect to receive under the Plan may be increased by the amount of such experience gain allocated to such Participant.

Note that if the Plan Administrator distributes the experience gains to the Participants by increasing coverage or distributing cash, the specific Participants whose excess premiums contributed to such experience gains in any given Plan Year may not necessarily be the ones who will receive a distribution of the experience gains. The individuals who will receive the experience gains will be the Employees who are enrolled in the Plan during the Plan Year(s) in which the Plan Administrator has determined that a distribution of experience gains will be made. Such experience gains will be allocated to the Participants on a reasonable and uniform basis. Federal law prohibits basing the amount of experience gain to be distributed to each Participant on the amount forfeited by the Participant.

When determining the amount to deposit in your Account for the upcoming year, you can minimize your risk of forfeiture by reviewing your health care expenses from past years, and anticipating changes.

Each time you are reimbursed from your Account, you may receive a withdrawal statement that shows recent deposits and your current balance.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of coverage under the Plan. 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 Plan when you or they would otherwise lose group health coverage.

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 Plan and under federal law, you may contact the Plan Administrator or the COBRA Administrator.

One of the Plan Administrators of the Plan is the North America Health and Insurance Plans Leader for The Dow Chemical Company:

North America Health and Insurance Plans Leader
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Active Employees: 1(877) 623-8079
Retired Employees: 1(800) 344-0661

COBRA continuation coverage for the Plan 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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the Plan 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 Plan is lost because of the qualifying event. Under the Plan, 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 Plan 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, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your Spouse dies;

(2) Your Spouse's hours of employment are reduced;

(3) Your Spouse's employment ends for any reason other than his or her gross misconduct (only applicable to Spouses who are active 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.

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

(1) The parent-Employee 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 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 Plan as a "Dependent Child."

When is COBRA Coverage Available?

A Participant has no right to COBRA continuation coverage if, as of the date of the qualifying event, the Participant has spent the entire balance of his or her Account.

The Plan 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 the employee'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.

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 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 Service Center. 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 or Dependent Child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

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 may elect continuation coverage, or only one of you. You may elect COBRA continuation coverage on behalf of your Spouse, 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.

What is the Maximum Continuation Coverage Period?

The maximum COBRA coverage period for the Plan is the period beginning on the date of the qualifying event and through the last day of the Plan Year in which the qualifying event occurred.

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; (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. Continuation coverage may also be terminated for any reason the Plan

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 Plan 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.

How Much Does COBRA Continuation Coverage Cost?

The monthly COBRA premium for coverage under the Plan maintained by the employer is 102% of the monthly contribution that the Employee was paying via salary reductions before the date of the qualifying event. If you elect COBRA continuation coverage, you must pay 102% of the monthly contribution amount you enrolled for under the Plan. (These payments may not be made from pre-tax dollars.) If you do not use your entire Account balance by the end of the Plan Year, then any unused amounts will be forfeited after the deadline for incurring and submitting claims.

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 under the Plan.*

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated 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 Plan, 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 Plan 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 described 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 Plan.

If You Have Questions

Questions about the Plan's COBRA coverage 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 www.healthcare.gov.

Keep the Plan 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.

Filing a Claim and Appealing a Denial of a Claim

See *APPENDIX I: CLAIMS PROCEDURES APPENDIX*.

Fraud Against the Plan

If you intentionally misrepresent information to the Plan, knowingly withhold relevant information from the Plan, or deceive or mislead the 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 paid to you by the Plan, including all costs of collection such as attorney's fees and court costs; and/or (3) prohibit you from enrolling in the Plan. In addition, your employer may terminate your employment, pursue civil and/or criminal action against you, or take other legal action.

Tax Considerations

Your Account contributions reduce your taxable income, allowing you to pay taxes on a smaller amount of income each payday.

IRS federal income tax provisions allow an itemized deduction when your eligible health care expenses exceed a certain percentage of your adjusted gross income. You may wish to consult a tax advisor.

Note: You may not reimburse an expense from your Account under the Plan *and* claim an itemized deduction for that expense on your income taxes.

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 or benefits. You or your Dependents shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

Your Legal Rights Under ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This law requires that all Plan 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 Plan, including collective bargaining agreements (if applicable), the Plan Document and the latest annual report (Form 5500 Series) 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 Plan, including collective bargaining agreements (if applicable) and copies of the latest annual report (Form 5500 Series), 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 must pay for such coverage. See *COBRA Continuation Coverage* for more information.

In addition to creating rights for you and all other Plan Participants, ERISA imposes duties on the people who are responsible for operating an employee benefit plan. The people who operate the Plan, 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 the 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 Plan Administrator 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 Plan fiduciaries misuse the Plan'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 Plan'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 *Litigation*.

Assistance with your questions: If you have any questions about the Plan, you should contact the Plan Administrator. 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, N.W., Washington, D.C. 20210. You may also 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.

Plan Administrator's Discretion

The Plan Administrators are the Global Benefits Director and North America Health and Insurance 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 *APPENDIX I: CLAIMS PROCEDURES APPENDIX*.

Plan Document

The Plan 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.

No Government Guarantee of Welfare Benefits

Welfare benefits, such as the HCRA or Limited Use HCRA, are not required to be guaranteed by a government agency.

Dow's Right to Terminate or Amend the Plan

The Company reserves the right to amend, modify, or terminate the Plan (including amending the Plan Document and the SPD) 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 or terminating the Plan are set forth in the Plan Document.

If the Company terminates the Plan, the assets of the Plan, if any, shall be used to:

(1) provide benefits under the Plan and pay the expenses of administering the Plan; or

(2) provide cash for Participants in accordance with applicable law.

Litigation and Class Action Lawsuits

Litigation

If you wish to file a lawsuit against the Plan (1) to recover benefits you believe are due to you under the terms of the Plan or any law; (2) to clarify your right to future benefits under the Plan; (3) to enforce your rights under the Plan; or (4) to seek a remedy, ruling or judgment of any kind against the Plan or the Plan fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Plan, you may not file a lawsuit until you have exhausted the claims procedures described in *APPENDIX I: CLAIMS PROCEDURES APPENDIX* 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.

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 Plan or to clarify your right to future benefits under the terms of the Plan, 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 Plan 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 Plan (other than a claim or action to recover benefits), the date the Plan 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.

Class Action Lawsuits

Legal actions against the Plan must be filed in U.S. federal court. Class action lawsuits must be filed in either (1) the jurisdiction in which the Plan 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 Plan, all parties to such action that are related to the Plan (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.

Incompetent and Deceased Participants

If the Administrator determines that you are not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan the Administrator may make benefit payments to your court-appointed legal guardian, to an individual who has become your legal guardian by

operation of state law, or to another individual whom the Administrator determines is the appropriate person to receive such benefits on your behalf.

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

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.

Waivers

A term, condition, or provision of the Plan 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.

Providing Notice to Administrator

No notice, election or communication in connection with the Plan that you or another 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.

Uncashed Checks

Benefit payments made by check that is not cashed or deposited, or by electronic funds transfer or other payment method that is not deposited (for example, because the Participant cannot be located), shall remain in the Company's general assets and shall not escheat to the state. Unless the Plan Administrator determines in its sole discretion that there are extenuating circumstances, the Plan's obligation to pay the benefit shall be extinguished if the check is not cashed or deposited, or electronic funds transfer or other payment is not deposited, within one (1) year after

the date of the check, transfer, or other payment method. Any benefits to which the check, electronic funds transfer, or other payment method relates will be forfeited.

The Administrator is entitled to rely on the last address provided to the Plan by you, and has no obligation to search for or ascertain your whereabouts.

No Assignment of Benefits

In general, except to the extent required by law or otherwise provided in the Plan Document or SPD, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or change of any kind.

For More Information

If you have questions, contact Aetna at 1-800-7-DOWDOW or the HR Service Center, 2511 E. Patrick Road, Midland, Michigan at 1-877-623-8079.

Important Note

This booklet is the Summary Plan Description (SPD) for The Dow Chemical Company Health Care Reimbursement Account Plan. The SPD is an integral part of the Plan Document; however, it is not all-inclusive and it is not intended to take the place of the Plan Document.

Dow reserves the right to amend, modify or terminate the Plan at any time in its sole discretion. The procedures for amending the Plan are contained in the Plan Document.

The Plan Document can be made available for your review upon written request to the Plan Administrator (whose contact information is listed under *ERISA Information*). This SPD and the Plan 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 Plan had never existed.

ERISA Information

The Dow Chemical Company
Health Care Reimbursement Account and Limited-use FSA
(Welfare Benefit Plan)

Plan Type:	Group health plan
Type of Plan Administration:	Administered by contract with Aetna, Inc.
Plan Sponsor:	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 1-877-623-8079
Employer Identification Number:	38-1285128
Plan Number:	508
Plan Administrator:	North America Health and Insurance Plans Leader or Global Benefits Director The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 1-877-623-8079
Claims Administrator for Claims for Plan Benefits:	To submit a claim for reimbursement (a Claim for Plan Benefits): Aetna FSA P.O. Box 4000 Richmond, KY 40475-4000 Fax: 1-888-AET-FLEX (1-888-238-3539) To appeal a denied Claim for Plan Benefits: Aetna Inc. P.O. Box 4000 Richmond, KY 40476-4000
Claims Administrator for an Eligibility Determination	To submit a Claim for an Eligibility Determination: Human Resources Operations Compensation and Benefits Manager or North America Health and Insurance Subject Matter Expert The Dow Chemical Company North America Benefits P.O. Box 2169

Midland, MI 48641
Attention: Initial Claims Reviewer for The Dow Chemical Company Health Care Reimbursement Account Plan (Eligibility Determination)

To appeal a denied Claim for an Eligibility Determination:

North America Health and Insurance Plans Leader or North America Health and Insurance Plan Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for The Dow Chemical Company Health Care Reimbursement Account Plan (Eligibility Determination)

To Serve Legal Process:

General Counsel
The Dow Chemical Company
Corporate Legal Department
2030 Dow Center
Midland, MI 48674

Plan Year:

The Plan's fiscal records are kept on a plan year beginning January 1 and ending December 31.

Funding:

The Plan is funded by Employee payroll deductions. Any assets of the Plan may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as the Plan may be amended from time to time, as well as to pay for expenses of the Plan. Such expenses may include, but are not limited to, consulting fees, actuarial fees, attorney fees, third party administrator fees and other administrative expenses.

APPENDIX I: CLAIMS PROCEDURES APPENDIX

A "Claim" is a written request by a claimant for reimbursement for medical expenses or for an eligibility determination:

- A Claim for Reimbursement is a written request for reimbursement of medical expenses covered under the 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 Plan or as to the amount a claimant must contribute towards the cost of coverage (for example, following termination of employment).

You must follow the claims procedures described in this Appendix for either *Claims for Reimbursement (Claims for Plan Benefits)* or *Claims for Eligibility Determinations*, whichever applies to your situation.

Who Will Decide Whether to Approve or Deny My Claim?

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

- ***Claims for an Eligibility Determination***. The Initial Claims Reviewers are the Human Resources Operations Compensation and Benefits Manager and the North America Health and Insurance Subject Matter Expert. The Appeals Administrators are the North America Health and Insurance Plan Manager and the North America Health and Insurance Plans Leader.

- ***Claims for Plan Benefits***. Aetna is the Initial Claims Reviewer and the Appeals Administrator.

Authority of the Claims Administrators

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Plan and to make findings of fact in order to carry out their respective Claims 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 Plan under Section 502 of the Employee Retirement Income Security Act (ERISA) in a federal court, provided you complete the claims procedures described in this *APPENDIX I: CLAIMS PROCEDURES APPENDIX* (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 *Litigation* for the deadline for filing a lawsuit.

An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Participant. The Plan 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 will also be recognized by the Plan.

Claims for Reimbursement (Claims for Plan Benefits)

For expenses covered by a medical or dental plan, you must first submit a Claim to that plan. After you receive an Explanation of Benefits ("EOB") statement showing any remaining unpaid expenses or a receipt for medical expenses for which you may not receive an EOB, such as prescription drug purchases, you may submit a Claim for reimbursement. To receive reimbursement for any expenses, you must timely submit a Claim for reimbursement. You have not timely submitted a valid Claim unless you have submitted a completed Reimbursement Request Form or online reimbursement request, in each case with all information that the Claims Administrator requires, by the deadlines described below, or unless your expense is submitted pursuant to the automatic roll-over feature.

If you are enrolled in the MAP Plus Option 1 Low Deductible Plan or a Delta Dental of Michigan Plan, which are eligible for the automatic roll-over feature, and you have elected to participate in such roll-over feature, your deductible, out-of-pocket amount and some non-covered medical expenses will be automatically sent to the Plan for processing. (Currently, the automatic rollover feature is not available when coordinating benefits with the MAP Plus Option 2 High Deductible Plan or a non-Dow medical plan.)

A Reimbursement Request Form is the document that describes the information that the Claims Administrator requires as part of a Claim. You may send a completed Reimbursement Request Form with the required supporting documentation to the address listed on the form or to the address listed below. Note: If you are covered by more than one group dental or medical plan, include *both* EOB statements. Be sure to keep copies of these documents for your tax records.

A Reimbursement Request Form can be obtained by calling the HR Service Center at 877-623-8079, or one can be printed off the Dow Intranet.

When you submit the Reimbursement Request Form, you must attach any documents required by the Claims Administrator. The Reimbursement Request Form with the required supporting documentation may be mailed or faxed to:

Aetna FSA
PO Box 4000
Richmond, KY 40475-4000

Fax: 1-888-AET-FLEX (1-888-238-3539)

Online reimbursement requests may be submitted at www.payflex.com.

Your Claims must be received by the Claims Administrator by April 30th of the year following the year in which the expense is incurred. If you incur an expense during the grace period from January 1 through March 15th, amounts remaining in your Account for the previous year will be used to reimburse the expense if it is submitted before April 30th. For example, if you have $300 left in your Account on December 31, 2017, and you incur $300 of qualified medical expenses any time between January 1, 2018, and March 15, 2018, those expenses will be reimbursed from your remaining 2017 HCRA balance if they are submitted for reimbursement on or before April 30, 2018. Expenses are "incurred" when you are provided with the medical or dental care, service, or product that gives rise to the expenses.

Initial Determination

When you submit a Claim for Reimbursement to the Initial Claims Reviewer, it will review your Claim and notify you of its decision to approve or deny your Claim.

Such notification will be provided to you within a reasonable period, not to exceed 30 days from the date you submitted your Claim; except that in special situations the Initial Claims Reviewer may have an extension of 15 additional days (totaling 45 days) to provide you such notification. If the Initial Claims Reviewer needs such an extension, it will notify you prior to the expiration of the initial 30 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 you did not provide sufficient information or filed an incomplete Claim, the Initial Claims Reviewer will describe any additional material or information needed. You will have 45 days to provide the requested information from the date you receive the notice from the Plan that it needs more information. In the Initial Claims Reviewer's sole discretion, the initial 30 day time period for it to make a decision to approve or deny your Claim, plus the 15 day extension period (if applicable) are tolled until the Initial Claims Reviewer receives your response. If you do not provide the information by the deadline, the Initial Claims Reviewer has the right to decide the Claim without the additional information.

If the Initial Claims Reviewer denies the claim, the written notification of the Claims decision will include:

(1) The specific reason(s) for denial of the Claim;

(2) References to the specific Plan provision(s) on which the denial is based;

(3) A description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary;

(4) If applicable, any internal rule, protocol, guideline or other criterion relied upon in making the decision, or a statement that such rule, protocol, guideline or other

criteria was relied upon and that a copy will be provided free of charge upon request if made within 180 days of the notification of denial of Claim;

(5) An explanation of the Plan's appeal procedures and the applicable time limits; and

(6) A statement of your right to bring a civil action under section 502(a) of ERISA, if your claim is denied upon review.

Appealing the Initial Determination

If the Initial Claims Reviewer has denied your Claim, you may appeal the decision. You must file a written appeal within 180 days of Aetna's decision, assuming that there are not extenuating circumstances, as determined by the Appeals Administrator in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

- Name of Employee
- Employee number
- Name of the Plan (The Dow Chemical Company Health Care Reimbursement Account Plan)
- Reference to the Initial Determination
- Explanation of the reason why you are appealing the Initial Determination

Send appeals for reimbursement benefit denials to:

Aetna Inc.
P.O. Box 4000
Richmond, KY 40476-4000

You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You may also 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, it 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 will take into Account all comments, documents, records, etc. submitted to it that is related to the Claim, without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator will consult a health

care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

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 Plan, 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.

If the Appeals Administrator denies your Claim on appeal , in full or part, the written notification of the decision will include:

(1) The specific reasons why the Claim you appealed is being denied;

(2) References to the specific Plan provision(s) on which the denial is based;

(3) A statement that you are entitled to receive, upon request, copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator in its sole discretion;

(4) If an adverse decision is based on the advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;

(5) If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request if the request is made within 120 days after the final decision;

(6) If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;

(7) A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and

(8) A statement of your right to bring a civil action under section 502(a) of ERISA.

Claims for Eligibility Determinations

A Claim for an Eligibility Determination must be in writing and contain the following information:

- The name of the person who is requesting the eligibility determination (employee)
- The name of the Plan for which the eligibility determination is requested (Health Care Reimbursement Account Plan)

Claims for Eligibility Determinations must be sent to:

Human Resources Operations Compensation and Benefits Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Initial Claims Reviewer for The Dow Chemical Company Health Care Reimbursement Account Plan (Eligibility Determination)

Initial Determination

If you submit a Claim for an Eligibility Determination, you must do so in writing before the end of the year in which you seek enrollment or before the end of the year for which you claim that your contributions to your Account were incorrect. 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 may 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 indicate 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 Plan 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:

- Employee's name
- Employee number
- Name of the Plan (The Dow Chemical Company Health Care Reimbursement Account Plan)
- Reference to the Initial Determination
- An explanation of the reason why you are appealing the Initial Determination

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

North America Health and Insurance Plan Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for The Dow Chemical Company Health Care Reimbursement Account Plan (Eligibility Determination)

You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You may also 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 will not be 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 may 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 Plan, 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.

APPENDIX II. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Effective Date of Notice: January 1, 2017

The Dow Chemical Company Medical Care Program, The Dow Chemical Company Retiree Medical Care Program, The Dow Chemical Company Dental Assistance Program, The Dow Chemical Company Retirement Health Care Assistance Plan: For Active Employees (Active RHCAP), The Dow Chemical Company Retirement Health Care Assistance Plan: For Retirees (Retiree RHCAP), The Dow Chemical Company Health Care Reimbursement Account, The Dow Chemical Company Executive Physical Examination Program (health care component only), The Dow Chemical Company Long Term Care Program, the Union Carbide Corporation Retiree Medical Care Program, the Union Carbide Corporation Insured Health Program, and the Rohm and Haas Company Health and Welfare Plan (collectively referred to in this document as the "Plan") are required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information created, received, transmitted or maintained by the Plan.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor[1] for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expense or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

B.1. NOTICE OF PHI USES AND DISCLOSURES

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the applicable Plan Sponsor for purposes related to treatment, payment and health care operations. As of April 14, 2003, the Plan Sponsors have amended their plan documents to protect your PHI as required by federal law.

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[1] The Plan Sponsor is The Dow Chemical Company for the following plans: The Dow Chemical Company Medical Care Program, The Dow Chemical Company Retiree Medical Care Program, The Dow Chemical Company Dental Assistance Program, The Dow Chemical Company Retirement Health Care Assistance Plan, The Dow Chemical Company Health Care Reimbursement Account, The Dow Chemical Company Executive Physical Examination Program, and the Rohm and Haas Company Health and Welfare Plan. The Plan Sponsor is Union Carbide Corporation for the following plans: Union Carbide Corporation Retiree Medical Care Program and the Union Carbide Corporation Insured Health Program.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, The Dow Chemical Company Dental Assistance Program may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

For example, The Dow Chemical Company Medical Care Program may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, The Dow Chemical Company Medical Care Program may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be obtained before any of the plans listed in the footnote[2] will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Uses and Disclosures Where You Have an Opportunity to Agree or Disagree Prior to the Use or Release Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure, have been given an opportunity to object and have not objected, or the Plan reasonably infers from the circumstances that you would not object to the disclosure.

Your written authorization is required before your PHI may be disclosed for most marketing purposes or disclosures that constitute a sale of PHI.

You may revoke your authorization in writing for these uses and disclosures at any time, but the revocation will not affect any disclosure made prior to the receipt of the revocation.

Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- To a business associate (e.g., a contractor) retained to perform services on behalf of the Plan when the business associate has agreed to safeguard your PHI.
- When required by law.
- When permitted for purposes of public health activities, included when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be the victim of abuse, neglect or domestic violence. In such case, the Plan will promptly

[2] The Dow Chemical Company Medical Care Program, The Dow Chemical Company Retiree Medical Care Program, Union Carbide Corporation Retiree Medical Care Program.

inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- When required for law enforcement purposes (for example, to report certain types of wounds).
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to conditions.
- When consistent with the applicable law and good standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Prohibited Uses and Disclosures

The Plan may not use or disclose PHI that is genetic information for underwriting purposes.

B.2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you indicate that disclosure by the regular means could pose a danger to you and you specify a reasonable alternative address or method of contract.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Requests to restrict uses and disclosures of your PHI should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

You have the right to receive notification following a breach of your unsecured PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. You have a right to obtain a copy of your PHI in electronic format where it is maintained in one or more designated record sets electronically. You have the right to request that the Plan transmit a copy of PHI to another individual at your request.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Request Amendment of PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

You or your personal representative will be required to complete a form to request an amendment of PHI in a designated record set. Requests for amendment of PHI in a designated record set should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. If the amendment is accepted, the Plan will inform you on a timely basis and obtain your agreement to notify the relevant persons with whom the amendment needs to be shared.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to an individual's authorization; (4) as part of a limited data set, or (5) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan may charge a reasonable, cost-based fee for each subsequent accounting. The Plan will inform you in advance of the fee and provide you with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

You or your personal representative will be required to complete a form to request an accounting of PHI disclosures. Requests for an accounting of PHI disclosures should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following person: Health Insurance Portability and Accountability Act (HIPAA) Privacy Official for ERISA Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

A Note About Personal Representatives

You may exercise your rights through a personal representative. A personal representative is a person legally authorized to make health care decisions on your behalf. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a non-emancipated minor child.

The Plan retains discretion to deny access to your PHI to a personal representative if the Plan has a reasonable belief that you may be subject to domestic violence, abuse, or neglect by the personal representative or if the Plan reasonably decides that it is not in the best interest to treat that person as your personal representative. This also applies to personal representatives of minors.

B.3. THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and eligible dependents) with notice of its legal duties and privacy practices.

This notice is effective beginning January 1, 2017, and the Plan is required to comply with the terms of this notice on and after that date. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to and after that date. If a privacy practice is changed, a revised version of this notice may be provided to those for whom the Plan still maintains PHI. The notices will be provided in the Choices enrollment brochures and updated versions of the summary plan descriptions or other appropriate means of communication.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard does not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures authorized by the individual; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

B.4. CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* parts 160 and 164. This notice attempts to summarize the regulations and set forth the Plan's legal duties, privacy practices, policies and procedures regarding your PHI. The regulations will supersede any discrepancy between the information in this notice and the regulations.