Summary Plan Description for:

The Dow Chemical Company Dependent Day 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Effective January 1, 2017 and thereafter until superseded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
Dependent Day Care Reimbursement Account

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The Dependent Day Care Reimbursement Account Plan

Overview

This is the Summary Plan Description ("SPD") for The Dow Chemical Company Dependent Day 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 dependent care expenses. Part of your salary can be directed into the Dependent Day Care Account. Based on your needs, and those of your family, you may consider participating in this Plan.

The Plan's reimbursements of qualified dependent care expenses are intended to be eligible for exclusion from a Participant's gross income under Section 129(a) of the Internal Revenue Code (the "Code"). The Plan document is intended to satisfy the written document requirement of Section 129(d)(1) of the Code. The Plan is not intended to be an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). 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 *General Plan 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.

Dependent Day Care Account Plan

Purpose and Highlights of the Plan

The Plan allows you to use pre-tax dollars to pay for eligible dependent care expenses incurred while you work. You determine the amount of your deposits, made through payroll deduction, to cover estimated dependent care expenses for the year. When expenses are incurred, you submit them to the Claims Administrator for reimbursement. In general:

- You are eligible to make pre-tax deposits for dependent day 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 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 totaling $100 to $5,000 each year per family for reimbursement of qualified dependent day care expenses if you enroll for participation. If you are married, your Spouse must also be employed or a full-time student or disabled and incapable of self-care.
- You should determine the amount of your pre-tax deposits by estimating your dependent day care expenses for the year.
- If you participate, you are reimbursed from your Account throughout the Plan Year, and through March 15 of the following year when you submit expenses.

Eligibility

You are eligible to participate in the Plan if your employment meets one of the classifications stated in Part A and you meet **both** of the requirements described in Part B.

Part A

- All active, Regular, Full-Time and Less-Than-Full-Time Salaried Employees and 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 of such collective bargaining agreement shall govern as to whether an Employee is eligible.

Part B

- You have a dependent who is a Qualifying Individual; and

- If you are Married, your Spouse is employed, unless he or she is a full-time student or disabled and incapable of self-care.

The applicable Claims Administrator determines eligibility. The Claims Administrator 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 *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

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 change in status.

- ***Change in Status***. Employees who have a 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*.

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 $5,000 per family in your Account each year. **When both you and your Spouse have access to employer-sponsored dependent care accounts, the total amount deposited in both accounts may not exceed $5,000.** If you and your Spouse file separate income tax returns, each of you is limited to $2,500 in deposits to a dependent care account per year.

The total amount deposited per family may not exceed your earned income or that of your Spouse. Your Spouse is deemed to have earned income of $250 per month if you have one Qualifying Individual or $500 per month if you have two or more Qualifying Individuals for each

month during which your Spouse is either (1) incapable of self-care and has the same principal place of abode as you for more than half of the year or (2) a full-time student.

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 Code as a "cafeteria plan." You may change the amount of your deposits only during annual enrollment, or if you have a "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 "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.

Change in Status

For purposes of the Dow Flexible Spending Plan, a "*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, or 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;

Consistency Rule

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

1. The 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.

Exceptions to the Change in Status and Consistency Rules

You may change the amount of your deposits mid-year without having met the "change in status" and consistency rule requirements only under the following circumstances:

- *Court Orders.* You may change your election mid-year if a court order resulting from a divorce, annulment, or change in legal custody, including a Qualified Medical Child Support Order, requires a change in your election to the Plan.

- *Significant Change in Cost of Current Dependent Care Provider.* If your current dependent care provider increases or decreases the amount the provider charges for service, you may make a corresponding change to your Plan election mid-year. This provision does not apply if the cost change is imposed by a dependent care provider who is your relative.

- *Change in Dependent Care Provider with Corresponding Change in Cost.* If you change your dependent care provider, and this results in a change in your dependent care costs, you may make a mid-year change to your Plan election. It does not matter whether the dependent care provider is your relative.

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 change in status event.

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

- If the Plan Administrator receives your enrollment and request within 31 days of the change in status event, the date of change in status event.

- If the Plan Administrator receives your enrollment and request on day 32 through 90 after the change in status event, 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

To be eligible for reimbursement from your Account, any qualified expenses must be incurred:

- for the care of a Qualifying Individual (as defined below) or for ordinary household services performed for the benefit of the Qualifying Individual by a Dependent Care Service Provider,

- on or after the date of your enrollment in the Plan, and

- in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.

Expenses incurred for the care received outside of your home for a Qualifying Individual, other than a child under age 13, are reimbursable only if the Qualifying Individual regularly spends at least eight hours each day in your household.

Types of Expenses that Are and Are Not Eligible for Reimbursement

Your Account* will *reimburse eligible dependent care expenses

In general, you may use your Account to reimburse the same types of expenses that qualify for the dependent care tax credit on your federal income tax return. IRS Publication 503 under the heading "Test to Claim the Credit" provides information regarding the types of expenses that qualify for the dependent care tax credit. Use the Publication with caution, however, because it was meant only to help taxpayers figure out whether they can claim the Dependent Care Tax Credit under Section 21 of the Code (described in the *The Dependent Care Tax Credit* section). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under the Plan.

Your Account will also reimburse* certain *educational expenses

Certain educational expenses may be eligible for reimbursement from your Account, such as:

- Nursery school.
- Charges for after-school care for children under age 13.

Your Account* will not *reimburse ineligible expenses

Other expenses are not eligible for reimbursement from your Account, such as:

- Tuition charged for children in kindergarten and beyond,
- Food, clothing, overnight camp or entertainment,
- Nursing home care, or
- Care for a child after the child's 13th birthday. For example, if a child has his or her 13th birthday on January 31st, no reimbursement may be made for expenses incurred on February 1st and for the remainder of the year.

Ask Aetna if you need further information about which expenses are – and are not – likely to be reimbursable, but remember that Aetna is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Dependent Care Service Provider

Dependent Care Service Providers generally include:

- A dependent day care center established and operating in compliance with applicable laws and regulations.
- An individual providing care in your home or at another location who is not your child (unless the child is age 19 or older by the end of the calendar year and is not claimed by

you or your spouse as a dependent for income tax purposes) or someone for whom you could claim a deduction on your federal income tax return.

- Pre-school educational institutions, such as nursery school.

- Programs for school-age children during non-school hours.

Note: You are required to include your caregiver's Social Security or federal tax identification number each time you submit a reimbursement claim under the Plan.

Qualifying Individuals

You may seek reimbursement of expenses from your Account for "Qualifying Individuals." A Qualifying Individual is:

- A person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child under age 13 is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or

- A person for whom you are entitled to claim a dependency deduction on your federal income tax return who is disabled and physically and/or mentally incapable of self-care and who resides with you for more than half the year (a "qualifying child" or "qualifying relative" as defined in Section 152(c) of the Code), or

- Your Spouse if he/she is disabled and physically and/or mentally incapable of self-care and who resides with you for more than half the year.

If you are a divorced parent, the Plan will recognize your biological or adopted child under age 13 as your Dependent if you have custody of the child, even if your former spouse, rather than you, is the one who is entitled to claim the dependency exemption. Under federal tax law, a non-custodial parent in a divorce situation cannot use the Plan to reimburse dependent care expenses for the child even if the non-custodial parent claims the child as a dependent for federal income tax purposes.

If You Leave Dow

If you leave Dow, retire, or transfer to an ineligible employee group, 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, or you may choose to suspend your Account. In either case you can use the amount in your Account toward qualifying expenses you incur during the remainder of the calendar year or during a grace period that extends until March 15th of the next year, even if you have suspended your deposits to the Plan. Your Account will remain open until the April 30th that occurs after the end of the year. After that date, any remaining balance will be forfeited. Note that 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 *CLAIMS PROCEDURES APPENDIX* for more information about how to submit Claims.

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. Under federal law, the total maximum amount may not exceed $5,000. Therefore, Participants who are at the $5,000 maximum will not be able to receive any experience gains and those just under the $5,000 maximum will be limited in the amount of experience gains that they will be able to receive.

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 dependent 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.

Filing a Claim and Appealing a Denial of a Claim

See *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. You may wish to consult a tax advisor to determine if the Plan or some other option is best for your situation. Neither the Company, nor any Participating Employer or any other affiliate, makes any assertion or warranty about (1) services 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.

The Dependent Care Tax Credit

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the Plan, although your qualified dependent care expenses *in excess of that amount* may be eligible for the *Dependent Care Tax Credit.*

The *Dependent Care Tax Credit* is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual qualified dependent care expenses. In determining what the tax credit would be for years after 2012 you may take into account $3,000 of such expenses for one Dependent or $6,000 for two or more Dependents. For example, if you elect $3,000 in coverage under the Plan and are reimbursed $3,000, but you had dependent care expenses totaling $4,000, then you could count the excess $1,000 when calculating the Dependent Care Tax Credit if you have two or more Dependents.

Depending on your adjusted gross income, the percentage of the Dependent Care Tax Credit could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Dependent or $2,100 for two or more Dependents). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000. For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses").

For most individuals, participating in the Plan will produce the greater federal tax savings, but there are some for whom the opposite is true. You should consult your own personal tax advisor.

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 the *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

The Plan is 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 for Participants under the Plan and pay the expenses of administering the Plan, and/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's parties-in-interest that relates to the Plan, you may not file a lawsuit until you have exhausted the claims procedures described in the *CLAIMS PROCEDURES APPENDIX* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred.

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 representative (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 Dependent Day 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 *General Plan 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.

General Plan Information

Plan Sponsor:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
1-877-623-8079 or (989) 638-8757

Employer Identification Number:

38-1285128

Plan Administrator:

North America Health and Insurance Plans Leader or the 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 40476-4000
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 Dependent Day 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 Dependent Day 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.

CLAIMS PROCEDURES APPENDIX

A "Claim" is a written request by a claimant for reimbursement for Dependent Care Expenses or for an eligibility determination:

- A Claim for Reimbursement is a written request for reimbursement of 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. ***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, provided you complete the claims procedures described in this *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)

To receive reimbursement for dependent day care expenses, you must timely submit a Claim for reimbursement to Aetna. 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.

A Reimbursement Request Form is the document that describes the information that the Claims Administrator requires as part of a Claim. 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.

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

The Claims Administrator will require, among other information, the following:

- Copies of your receipts for dependent day care expenses. The receipts must show the date(s) of services.
- The name, address and social security number or federal income tax identification number of the caregiver.

Your Claims must be received by Aetna 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 expenses any time between January 1, 2018, and March 15, 2018, those expenses will be reimbursed from your remaining 2017 Account balance if they are submitted for reimbursement on or before April 30, 2018. Expenses are "incurred" when the dependent care that gives rise to the dependent care expenses is rendered, except as provided in the next paragraph.

A reimbursement cannot be made before services have been rendered, unless the provider indicates the payment is non-refundable. If the payment is non-refundable, the reimbursement can be made 30 days in advance. If the payment is non-refundable, the Plan will treat the

expense as incurred on the date payment to the provider is made, which date may not be more that 30 days prior to the date services are rendered.

Aetna will not approve Claims for Reimbursement in excess of the balance in your Account.

A Reimbursement Request Form with the required supporting documentation can be mailed or faxed to:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Fax: 1-888-AET-FLEX (1-888-238-3539)

Claims for Eligibility Determinations

A Claim for an Eligibility Determination must be 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. Claims for an Eligibility Determination must contain the following information:

- The name of the person (*i.e.*, Employee) who is requesting the eligibility determination (employee).

- The name of the Plan for which the eligibility determination is being requested (The Dow Chemical Company Dependent Day 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 Dependent Day Care Reimbursement Account Plan (Eligibility Determination)

Initial Determination

If you submit a Claim for Reimbursement (Claims for Plan Benefits) or a Claim for an Eligibility Determination to the applicable Claims Administrator, the applicable 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 applicable Initial Claims Reviewer determines that it does not

have sufficient information to make a decision on your Claim, it will notify you and describe any additional material or information necessary for you to submit to the Plan and the deadline for submitting such information. If the applicable 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 applicable Initial Claims Reviewer has denied your *Claim for Reimbursement* (Claim for Plan Benefit) or *Claim for Eligibility Determination*, 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 applicable Appeals Administrator. Your written appeal must include the following information:

- Name of Employee
- Employee number
- Name of the Plan (The Dow Chemical Company Dependent Day 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 Dependent Day Care Reimbursement Account Plan (Appeal of Eligibility Determination).

Appeals of Reimbursement denials should be sent to:

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

You may submit any additional information to the applicable 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 applicable Appeals Administrator in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

After the applicable 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 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.

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 in part, the written notification of the decision will state the reason(s) for the denial and refer to the specific provisions in the Plan Document on which the denial is based.