Summary Plan Description "Wrapper" for:

Health Maintenance Organizations (HMOs) and Insured Health Plans Participating in:

The Dow Chemical Company Insured Health Program

(ERISA Plan #601)

APPLICABLE TO ELIGIBLE ACTIVE EMPLOYEES

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Effective January 1, 2017 and thereafter until superseded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.

DC: 6298935-6

Content Steward: Woodyard

January 1, 2017

Lit Number # 318-60934

Table of Contents

Section 1. ERISA Information

The Dow Chemical Company Insured Health Program

SPD Wrapper for HMOs and Insured Plans applicable to Eligible Active Employees

Type of Plan	Group health plan
Type of Plan Administration	Benefits provided under an insured arrangement with the HMO or insurer of your Plan.
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
Employer Identification Number	38-1285128
Plan Number	601
Plan Administrator	North America Health and Insurance Plans Leader The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641 (877) 623-8079
Dow HR Service Center	The Dow Chemical Company 2511 E. Patrick Road Midland, Michigan 48674 (877) 623-8079
Claims Administrators for Claims for Plan Benefits	*To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits*: Contact the applicable Plan HMO or insurer. See the materials provided by the HMO or insured health plan.
Claims Administrator for Claims 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, Michigan 48641 (877) 623-8079

	To appeal a denied Claim for an Eligibility Determination: North America Health and Insurance Plan Manager or North America Health and Insurance Plans Leader The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
To Serve Legal Process	The applicable Plan at the address provided by the HMO or insurer. or General Counsel The Dow Chemical Company 2030 Dow Center Midland, MI 48674
COBRA Administrator	Willis Towers Watson BenefitConnect COBRA Service Center P.O. Box 919051 San Diego, CA 92191-9863 (877) 292-6272
HMO Network Manager	Willis Towers Watson is the HMO Network Manager for HMOs offered to Employees and their Dependents. Willis Towers Watson 2511 E. Patrick Road Midland, Michigan 48674 (877) 623-8079
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	Participating Employers share the premium costs with Employees. Employee contributions are generally made through payroll deduction. Benefits are underwritten by the applicable Plan. The applicable HMO or insurer is liable to pay the benefits, not the Company or any Participating Employer. The assets of the Program, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other

	administrative expenses.
EAP	Aetna Employee Assistance Program 151 Farmington Avenue Mailstop RS 32 Hartford, CT 06156

Section 2. Introduction

Summary Plan Description "Wrapper"

This is the Summary Plan Description "Wrapper" ("SPD Wrapper") for Health Maintenance Organizations (HMOs) and insured health plans (except The Dow Chemical Company International Medical and Dental Plan) that are offered through The Dow Chemical Company Insured Health Program (the "Program") as applicable to eligible active Employees. The HMOs and insured plans (other than The Dow Chemical Company International Medical and Dental Plan) offered by the Program are listed each Fall in the annual enrollment materials. In this SPD Wrapper, the HMOs and insured plans offered by the Program (other than The Dow Chemical Company International Medical and Dental Plan) to Employees are referred to collectively as the "Plans" and individually as a "Plan."

This SPD Wrapper addresses:

- ERISA Information
- Eligibility for Coverage
- Enrollment
- Mid-Year Election Changes and HIPAA Enrollment Provisions
- Premiums
- Survivor Benefits
- Disclosures Required by Law
- Fraud Against the Program
- Ending Coverage and Your Rights under COBRA
- Your Legal Rights under ERISA
- Plan Administrator's Discretion
- Plan Document (scrivener's error)
- Welfare Benefits
- Dow's Right to Terminate or Amend the Program
- Disposition of Plan Assets if the Program is Terminated
- Litigation and Class Action Lawsuits
- Incompetent and Deceased Participants
- Privilege, Waivers, and Notices
- Funding

- Payment of Unauthorized Benefits
- Filing and Appealing Claims for an Eligibility Determination

This SPD Wrapper does not include all of the information about benefits under the Plans. Further information can be found in the Plan Document for the Program, as well as in materials provided to you by the applicable Plan. The materials provided by the Plan:

- Benefits covered under the applicable Plan and the coverage
- Terms and Conditions for benefits coverage under the applicable Plan
- Copays, deductibles, out-of-pocket maximums and coverage limitations
- Filing and appealing Claims for Plan Benefits
- Precertification or preauthorization requirements
- In-network and out-of-network provisions, if any
- Primary care physician requirements, if any
- HIPAA notice of privacy practices
- Any other provisions of the applicable Plan

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

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

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

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

The provisions of this SPD Wrapper apply only to Plans offered through the Program. For information about other Dow-sponsored plans that may be available to you, check the Dow Intranet or call the Human Resources (HR) Service Center at (877) 623-8079.

Capitalized words in this SPD are defined in the Plan Document, in *Section 28. Definitions of Terms* or in the materials provided by the Plans.

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Employee Assistance Plan

If you are an Employee enrolled in a Plan under the Program, you are eligible for free Employee Assistance Plan ("EAP") services. The EAP provides professional and confidential counseling on emotional, social and mental health issues for employees and dependents experiencing personal difficulties. Participation is voluntary and typically self-referred. EAP support is available 24-hours per day, 7-days per week. The EAP provides up to six visits to an EAP counselor for assessment and referral or short-term counseling. The types of issues supported by EAP include:

- Interpersonal relationships
- Anxiety/stress
- Depression/mental health issues
- Teen/Parent relationships
- Separation/Divorce
- Financial/legal problems
- Grief/loss
- Anger management/violence

When EAP services are not medical in nature, they are called "EAP Direct Services." The part of the EAP that provides EAP Direct Services is not part of any HMO plan or insured plan offered under the Program.[1] Sometimes, during EAP counseling sessions, a limited amount of mental health counseling occurs, which is medical in nature. The part of the EAP that provides these limited mental health services is a component of each of the HMOs or insured plans under the Program called "Medical EAP."

The EAP is administered by Aetna:

Aetna Employee Assistance Program
151 Farmington Avenue
Mailstop RS 32
Hartford, CT 06156

To contact a local EAP provider, go to:

http://myhr.intranet.dow.com/all/benefits/other_benefits/en/employee_assist.aspx

While Medical EAP provides limited mental health benefits at no cost to you, if you are enrolled in a Plan under the Program, the Plans also provide more extensive mental health coverage; that coverage and the costs of coverage are described in the materials provided by your HMO or insurer describing the benefits the Plan provides.

Am I Still Eligible for the EAP If I Am Not Enrolled In a Plan under the Program?

Yes. If you decided not to enroll in a Plan under the Program, you are still eligible for free EAP benefits if you are an Employee, and:

- If you are enrolled in another Dow employee medical plan, Medical EAP benefits are provided by the plan in which you are enrolled.
- If you are not enrolled in any Dow employee medical plan, Medical EAP benefits are provided under the MAP Plus Option 1 Low Deductible Plan offered under The Dow Chemical Company Medical Care Program.'
- If you die on or after May 7, 2015, while you are eligible for EAP services, your surviving Spouse/Domestic Partner and Dependent Children will be eligible for EAP services for up to one year after the date of your death.

Regardless, your EAP benefits are administered by Aetna at the Farmington Avenue address above.

---

[1] EAP Direct Services are not offered under Dow ERISA Plan #501 or Dow ERISA Plan #601, or any other Dow-sponsored ERISA plan.

EAP Benefits Grandfathered Under Health Care Reform

To the extent the EAP is a group health plan, the EAP is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act, commonly referred to as Health Care Reform). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the EAP may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the contact information listed under *Section 1. ERISA Information*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 3. About HMOs and Insured Plans

3.1 How HMOs Operate

HMOs are a form of prepaid medical assistance designed to help keep you and your family healthy by encouraging regular checkups and early detection of medical problems. Some HMOs provide services in an HMO-owned facility, perhaps with satellite facilities, staffed by their own physicians, specialists, and other health care professionals. Others offer services through independent medical offices or through physicians and specialists under contract with the HMO.

The intent of an HMO is to maintain the health of its members while ensuring medical coverage when needed. The HMO provides services for emergencies and medical conditions, but the emphasis is on preventive medicine. In addition, HMOs try to reduce medical expenses by conducting, when possible under one roof, routine health maintenance services that are most commonly used by members.

Generally, when you join an HMO, you select a Primary Care Physician (PCP) from the HMO staff. You agree to use the HMO's facilities and staff, or those under contract to the HMO, instead of obtaining services from physicians, specialists or facilities not affiliated with the HMO.

Your PCP will be responsible for managing health care for you and your family. However, an HMO physician can, on occasion, refer you to a non-affiliated provider. Services obtained from any physician or facility not affiliated with the HMO will not be covered by the HMO unless authorized by an HMO physician, or provided under emergency conditions.

An HMO concentrates its resources in a specific geographic area, sometimes a county or an area defined by residential zip codes. Most HMOs do not provide coverage outside their service area, other than for emergencies, life-threatening conditions or referrals by the PCP.

HMOs should not refuse to provide services or coverage because of a labor dispute involving employees of the HMO. Generally, you will not be billed directly by the HMO for any medical services – except for charges such as copayments for services only partially covered by the HMO.

Any disagreement between you and the HMO becomes a matter to which you and the HMO should respond. For example, if you disagree with the HMO over a settlement of a Claim, or have any questions concerning a physician referral, you should follow the review and appeals procedures of that HMO. Any charge not paid by the HMO becomes your responsibility – not Dow's. If an HMO fails to pay a charge

directly to a health care provider or fails to provide coverage for an expense you feel should be covered, the disagreement should be settled between you and the HMO.

In general, if you leave Dow employment, you may convert to an individual policy with your HMO. Also, under certain circumstances, you may continue coverage for you and your Dependents for a limited time under the rules established in the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See *Section 11.2 COBRA Continuation Coverage* for details, or contact the Dow HR Service Center for details about COBRA. For details about converting your HMO coverage to an individual policy, contact your HMO (at the contact information listed in the materials it provides you) or Willis Towers Watson (at the contact information listed in *Section 3.4 Willis Towers Watson, the HMO Network Manager*).

3.2 Dow and the Plans

When you enroll in a Plan under the Program, you are not enrolled in a benefit plan designed or administered by Dow, except for Dow's involvement in determining whether you meet the Program's eligibility rules described in this SPD Wrapper. Instead, you are enrolled in an independent medical plan that is operated by an HMO entity or insurer separate from Dow. By enrolling in a Plan you agree to obtain your health care coverage through the HMO or insurer. Dow's primary contact with the HMO or insurer is the payment of insurance premiums.

3.3 Information that Your HMO Should Provide You

Each HMO or insurer will supply you, upon written request, written materials concerning:

- the nature of services provided under the Plan;
- conditions pertaining to eligibility to receive such services, other than general conditions pertaining to eligibility required by Dow described in this SPD Wrapper;
- the circumstances under which services can be denied;
- the procedures to be followed in obtaining such services and the procedures available for the review of the Claims for Plan Benefits that are denied in whole or in part.

3.4 Willis Towers Watson, the HMO Network Manager

Dow has contracted with Willis Towers Watson, Inc. to serve as Dow's HMO Network Manager and to manage the HMOs that participate in the Program. If you would like more information regarding the availability of HMOs in your area, or do not know how to contact your HMO, contact Willis Towers Watson at (877) 623-8079. Willis Towers Watson will also assist you in obtaining HMO materials if you need help getting them from the HMO.

3.5 Grandfathered HMOs

Dow believes that certain HMOs offered under the Program are "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA), commonly referred to as federal health care reform. Contact the HMO directly or refer to the materials provided by your HMO if you want to know whether the HMO plan is grandfathered.

Being a grandfathered health plan means that the plan may not include certain consumer protections of PPACA. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources (HR) Service Center, Employee Development Center, Midland, Michigan 48674, telephone (877) 623-8079. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

Section 4. Eligibility

4.1 Plan Availability

Besides meeting the eligibility criteria described in this SPD Wrapper, in order to participate in a particular Plan, you must be located where the Plan is available. If you move and thereby cease to be eligible for your Plan, you may change your enrollment. See *Section 5.5 If You Move out of the Plan Covered Location during the Plan Year*.

4.2 Eligibility for Employees and Certain Disabled Individuals

Employee Eligibility

You are eligible for medical coverage under the Program if you are not covered by the Dow International Medical and Dental Plan, and you:

- Are an active, Regular, Full-Time or Less-Than-Full-Time Salaried U.S. Employee of a Participating Employer; or
- Are an active, Regular, Full-Time Bargained-for U.S. Employee of a Participating Employer whose Bargaining Unit and Participating Employer have agreed to the Program. However, if the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Program, then the terms such collective bargaining agreement shall govern.

If you do not meet the eligibility requirements above, you still may be eligible, for example, if you live in Hawaii and your Participating Employer is required by state law to provide you coverage. Please contact the Claims Administrator for Claims for Eligibility Determinations for more information regarding whether you are eligible to participate in the Program.

Benefit Protected Leave of Absence

Eligibility for benefits under the Program may continue during certain benefit-protected leaves of absences approved by the Participating Employer such as under the Company's Military Leave Policy, Family Leave Policy or Medical Leave Policy. The benefits under the Program shall be administered consistent with the terms of such approved leaves of absences.

International Medical and Dental Plan

Expatriates and their eligible Dependents should refer to the summary plan description for the Dow International Medical and Dental Plan to determine their eligibility and coverage under that plan. Those who are eligible for coverage under the Dow International Medical and Dental Plan are not eligible for coverage under HMOs or other insured plans offered under the Program.

Severance Agreement

You may be eligible to participate in the Program after you terminate employment if provided in accordance with the severance plan or documents signed by your Participating Employer or its authorized agent. The terms of your continued participation in the Program will be governed by the terms of the applicable severance plan documents or agreement.

4.3 Dependent Eligibility

Eligible Employees can enroll their eligible Dependents. A Dependent may be either your Spouse, your Domestic Partner, or an eligible Dependent Child. You must be enrolled in order to enroll a Spouse/Domestic Partner or Dependent Child. If you enroll your Spouse/Domestic Partner or Dependent Child, you will be required to provide their Social Security number to the Program.

The Program requires proof of Dependent eligibility, such as birth certificates, passports, Marriage certificates, Domestic Partner signed statements or any other form of proof the Plan Administrator deems appropriate.

Spouse and Domestic Partner Exclusions

Your Spouse or Domestic Partner is not eligible for coverage under the Program if he or she is:

- Eligible for subsidized coverage as a full-time employee or retiree under another employer's plan, but not enrolled for personal coverage in that plan.[2] See *Working or Retired Spouse/Domestic Partner Rule*, immediately below;
- Enrolled for coverage as an Employee or Retiree (or other former Employee) under another Dow or Dow-affiliated medical plan; or
- Serving in the armed forces of any country.

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

Working or Retired Spouse/Domestic Partner Rule

If your Spouse/Domestic Partner (1) is not eligible for Medicare and (2) is working full time or is retired and his or her employer (or former employer) offers subsidized employer-sponsored health coverage to its employees or retirees, he or she may not be covered as a Dependent under the Program unless he or she has enrolled in the employer-sponsored health coverage. This rule applies no matter how large or small the subsidy offered by your Spouse/Domestic Partner's employer is or what the premiums are. If your Spouse/Domestic Partner's employer offers more than one type of health coverage (e.g., more than one group health plan), your Spouse/Domestic Partner must enroll in the coverage that is most comparable to the Plan in which you are enrolled.

If your Spouse/Domestic Partner has coverage through his or her employer, as described in the preceding paragraph, and you enroll your Spouse/Domestic Partner in the Plan, the following rules apply:

- If your Spouse/Domestic Partner has enrolled in coverage offered by his or her employer (or former employer), the payment of benefits under the Plan will be secondary to your Spouse/Domestic Partner's coverage through his or her employer (or former employer) under the Plan's coordination of benefits rules.
- If your Spouse/Domestic Partner fails to enroll in appropriate coverage available through his or her own employer (or former employer):
    1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Spouse/Domestic Partner was enrolled in the Plan and failed to enroll in his or her own employer's coverage.

---

[2] However, if your Spouse/Domestic Partner is a Dow Retiree or an LTD Participant who is eligible for coverage under the Program because of his or her prior employment with Dow and is eligible for active medical coverage under another employer's plan, your Spouse/Domestic Partner is not required to enroll in that coverage in order to have coverage under the Program.

2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer), the Program may cancel coverage for you and/or your Spouse/Domestic Partner retroactive to the first day that your Spouse/Domestic Partner failed to enroll in the employer's coverage. If coverage is cancelled, you will be required to reimburse the Plan for claims paid during the coverage period. See *Section 24. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Spouse/Domestic Partner were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer by the date determined by the Plan Administrator, coverage will terminate as of the date that the Program learns that your Spouse/Domestic Partner failed to enroll in the employer coverage.
4. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer, your Spouse/Domestic Partner will remain covered under the Plan for the Plan Year.

Additional or alternative actions might be taken on account of your or your Spouse/Domestic Partner's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

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

Waiving Coverage – Working Spouse/Domestic Partner

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

Dependent Child(ren)

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

- your birth or legally adopted child; or
- your Spouse's or Domestic Partner's natural or adopted child; or
- a child for whom you or your Spouse/Domestic Partner have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have

permanently "legally relinquished all of their parental rights" in a court of law. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:

- authority to consent to the child's marriage or adoption, or
- authority to enlist the child in the armed forces of the U.S.;
- right to the child's services and earnings; and
- power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

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

Dependent Child(ren) Exclusions

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

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

When your child is no longer eligible for Dependent coverage because of one of the above events, you may be eligible to make a new enrollment within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs. For information about rights your child may have for continuation of coverage under the Program as provided by the federal COBRA law, see *Section 11.2 COBRA Continuation Coverage*. Note: In order for your Dependent to receive COBRA continuation coverage, you must provide notice that your child is no longer an eligible Dependent within 60 days after your Dependent becomes ineligible.

4.4 Eligibility through a Qualified Medical Child Support Order

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

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

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

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

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

4.5 Eligibility Determinations of Claims Administrator Are Final and Binding

The applicable Claims Administrator determines eligibility. The Claims Administrator is a fiduciary of the Program and has the full discretion to interpret provisions of the SPD and the Plan Document and to make findings of fact. However, the Claims Administrator's determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants. If you would like the applicable Claims Administrator to determine whether you are eligible for coverage, you can file a Claim for an Eligibility Determination. See *Section 25. Claims Procedures*.

Section 5. Enrollment

5.1 Levels of Participation

The levels of participation available are:

- Employee Only
- Employee plus Spouse
- Employee plus Domestic Partner
- Employee plus Child(ren)
- Employee plus Spouse and Child(ren)
- Employee plus Domestic Partner and Child(ren)

You must be enrolled in order to enroll your Dependent. In general, you may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the Kaiser HMO, your Dependent may not be enrolled in Blue Care Network or one of the MAP Plus plans.

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

5.2 Enrolling at the Beginning of Employment

To enroll for Program coverage upon your hire, enroll on the Dow Benefits web site or by calling the HR Service Center within 90 days of your date of hire.

- *If your enrollment is received within 31 days of your first day at work*, coverage is effective on your date of hire.

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

If you do not enroll within 90 days of your date of hire, you will not have coverage, and you will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 6. Mid-Year Election Changes*).

Enrolling Your Spouse/Domestic Partner and Dependent Child(ren) at the Beginning of Employment—Proof of Eligibility

If you are enrolling your Spouse/Domestic Partner and/or Dependent Child(ren), you must provide proof of their eligibility within 90 days of your date of hire. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

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

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

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

2. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, coverage will terminate as of the 90th day after your date of hire.
3. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

5.3 Enrolling During Annual Enrollment

Annual enrollment is typically held during the last quarter of the year and is handled electronically. You may enroll for coverage, switch plans or waive coverage at this time.

Enrolling Your Spouse/Domestic Partner and Dependent Child(ren) During Annual Enrollment—Proof of Eligibility

If you wish to add a Dependent – either a Spouse/Domestic Partner or a child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. You must provide proof of Dependent eligibility no later than 90 days after the start of the applicable Plan Year. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

If you do not provide proof of Dependent eligibility no later than 90 days after the start of the Plan Year:

1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan (i.e., January 1st).
2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for your Dependent. See *Section 25. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of the 90th day after the start of the Plan Year.
4. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

If your Spouse is enrolled in a Plan, you may not dis-enroll your Spouse in anticipation of a divorce. You are required to continue coverage for your Spouse and pay the applicable premium. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), when your legal separation or divorce is final, your Spouse has a right to continue coverage under the Plan at 102% of the full cost of coverage for a certain period of time. See *Section 11.2 COBRA Continuation Coverage* for more information about COBRA coverage.

Default Enrollment

If at annual enrollment you fail to enroll or affirmatively waive coverage under the Plan within the time period specified in the annual enrollment brochure, your current medical plan elections will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible for the coverage in which you are enrolled. However, each year, you must provide acceptable proof of your compliance with the *Working or Retired Spouse/Domestic Partner Rule*.

5.4 Dual Dow or UCC Coverage

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

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

5.5 If You Move out of the Plan Covered Location during the Plan Year

If you move during the Plan Year and remain eligible to participate in the Program, but your Plan is not offered at your new location, you may switch your coverage to a Plan that is available under the Program at the new location or switch to a self-insured plan offered under The Dow Chemical Company Medical Care Program. If you want to continue receiving health coverage under a Dow-sponsored plan after you move, you must notify the HR Service Center within 90 days of your transfer (or 180 days for geographic location under the Participating Employer's relocation policy).

5.6 Change of Elections to Prevent Discrimination

The Plan Administrator has the authority to change the benefit elections of certain Participants if such a change is necessary to prevent the Program from becoming discriminatory within the meaning of Section 125(b) of the Internal Revenue Code (the "Code"). If the Plan Administrator determines or is informed by the plan administrator of The Dow Chemical Company Flexible Spending Plan (the "Dow Flexible Spending Plan") before or during any plan year that the Dow Flexible Spending Plan may fail to satisfy, for such plan year, any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to key Employees or Highly Compensated Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or key Employees with or without the consent of such Employees.

Section 6. Mid-Year Election Changes

In general, you purchase your Employee, Spouse, and Dependent Child coverage under the Program with premiums that are 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 your medical coverage level only during annual enrollment, or if you have a special enrollment event or a "change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan).

Generally, you may not enroll in the Plans outside of the enrollment periods described in Section 5 and pay premiums on a pre-tax basis unless you meet the requirements of this Section 6.

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

This section of the SPD describes special enrollment events, the definition of "change in status" and the consistency rules, and exceptions to these rules, as well as the documentation required and deadlines for making a mid-year election change.

6.1 Special Enrollment Provisions

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

- ***Loss of Other Medical Coverage***. If you decline enrollment in the HMOs or insured plans for you or your Dependents (including your Spouse/Domestic Partner) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependents outside of the usual annual enrollment period if you or your Dependent lose eligibility for the other coverage or the other employer ceases to make employer contributions for the other coverage. In order to have coverage under the Plan, you or your eligible Dependent must enroll in the Plan

within 90 days after the other coverage ends. However, if you or your Dependent declined Dow-sponsored coverage because of other coverage provided through COBRA, you or your Dependent must wait until the annual enrollment period unless the entire period of coverage available under the COBRA coverage has been exhausted. An individual need not elect COBRA coverage under another health plan in order to use these special enrollment provisions.

- ***Marriage, Birth, or Adoption***. If you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may receive coverage under the Program for yourself and your new Dependent if you enroll in the Program within 90 days after the Marriage, Domestic Partnership, birth, adoption, or placement for adoption.
- ***Loss of Medicaid or SCHIP***. If you or your Dependent either (i) loses coverage under Medicaid or a State Child Health Insurance Plan ("SCHIP"), or (ii) becomes eligible for premium assistance under the Program through Medicaid or SCHIP, you may receive coverage for yourself and your Dependent if you enroll within 90 days.

In order to enroll in the Program because of a special enrollment event described above, you must provide proof of the event in accordance with *Section 6.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *Section 6.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 6.7 Deadline to Enroll for Mid-Year Changes*.

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

6.3 Consistency Rules

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

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

6.4 Exceptions to the Change in Status and Consistency Rules

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

- ***Court Orders*** – You may change your election mid-year if a court order resulting from a divorce, annulment, or change in legal custody (including a Qualified Medical Child Support Order), requires a change in your medical plan election.
- ***Entitlement to Medicare or Medicaid*** – If you, your Spouse/Domestic Partner or Dependent are enrolled in the Program and become entitled to coverage (*i.e.*, enrolled) under Medicare or Medicaid mid-year (other than for coverage consisting solely for distribution of pediatric vaccines), you may cancel your Program coverage.
- ***Significant Cost or Coverage Changes*** – If your Spouse/Domestic Partner is covered by his or her employer's plan, which allows him or her to change his or her benefit plan election because of a significant change in cost or coverage under the employer's plan, such change in your Spouse/Domestic Partner's election will allow you to change your Dow election. If your Spouse/Domestic Partner's employer's enrollment period is different from Dow's, your Spouse/Domestic Partner's election under his or her employer's plan may constitute a significant coverage change allowing you to change your Dow election.
- ***Special Enrollment Rights*** – You may change your Program election mid-year if you meet the special enrollment requirements addressed in *Section 6.1 Special Enrollment Provisions*.

6.5 Examples Applying the Mid-Year Election Change Rules

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

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll, you may increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse), or you may change to a different coverage option (*e.g.*, from MAP Plus Option 1 to MAP Plus Option 2 or an HMO).
Lose a Dependent • Divorce • Death • Dependent loses eligibility • Termination of Domestic Partnership	You may decrease your level of participation (*e.g.*, Employee plus Spouse to Employee Only). You may not change to a different coverage option (*e.g.*, from MAP Plus Option 1 to MAP Plus Option 2 or an HMO).
Spouse/Domestic Partner loses medical coverage elsewhere	You may enroll, increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse), or change to a different coverage option (*e.g.*, from MAP Plus Option 1 to MAP Plus Option 2 or an HMO).

Event	Permissible Change
Move out of Plan service area	You may change to a different coverage option if you were enrolled in a Plan and move out of the Plan's service area. You may not change your level of participation (*e.g.,* Employee Only to Employee plus Spouse).
Move into a Plan service area	You may enroll in or change to a Plan for which you become eligible as a result of moving. You may not otherwise switch your coverage option (e.g., from MAP Plus Option 1 to MAP Plus Option 2, or *vice versa*) or change your level of participation (*e.g.,* Employee Only to Employee plus Spouse).

6.6 Documentation of Eligibility Required to Make Election Change

Documentation is required to show proof of eligibility to make an election change and/or to show proof of Dependent eligibility. Required documentation may include birth certificates, passports, Marriage certificates, Domestic Partner signed statements, Social Security Numbers, evidence of loss of Spouse/Domestic Partner or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Program reserves the right to, at any time, request proof of eligibility.

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

1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that you and/or your Dependent was enrolled in the Plan.
2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for you and/or your Dependent retroactive to the first day that you and/or your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for you and/or your Dependent. See *Section 25. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of eligibility by the date determined by the Plan Administrator, coverage will terminate as of the 90th day after the change in status or special enrollment event.
4. If, by the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of eligibility, you and/or your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

Dropping or Adding a Domestic Partner

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

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

6.7 Deadline to Enroll for Mid-Year Changes

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

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

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

Section 7. Premiums

7.1 Your Contribution

You and Dow share the premium costs for your medical coverage. Your contributions to premiums are paid through payroll deductions. For your portion of the monthly premium, refer to the materials provided during the annual enrollment period. The amount you pay is the difference between the total cost of HMO/insured plan coverage and Dow's contribution to the premium costs.

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

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

The Company's contribution towards the monthly cost for coverage for a Less-Than-Full-Time ("LTFT") Employee is pro-rated, except that a LTFT Employee who has 70 Active Employee Points shall be offered coverage at the same Employee contribution amount that a Full-Time Employee pays.

7.2 Failure to Pay Required Premiums

Your failure to pay the full amount of premiums due by the date required by the Plan Administrator may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. The Plan Administrator, in its sole discretion, may determine whether you are delinquent in paying premiums.

In general, you are considered delinquent if required premiums are more than 90 days past due. If you become delinquent in paying premiums:

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

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

In addition, the provisions of *Section 24. Payment of Unauthorized Benefits***Error! Reference source not found.**, may apply if benefits were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

7.3 Excess Premium Payments

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

7.4 Premiums During a Benefits Protected Leave of Absence

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

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

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

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

Section 8. Survivor Benefits

8.1 General Rule

In general, a surviving Spouse/Domestic Partner of an active Employee is eligible for 36 months of COBRA coverage if he or she was under a Plan at the time of death. See *Section 11.2 COBRA Continuation Coverage*.

8.2 Exceptions to the General Rule

As explained below, special rules apply for certain participants in certain Dow-sponsored pension plans. You or your surviving Spouse/Domestic Partner may obtain a copy of an applicable retiree medical SPD from the Dow HR Service Center. The retiree medical SPD provides eligibility and cost information about the coverage available to survivors. If your surviving Spouse/Domestic Partner is enrolled for coverage under an applicable retiree medical plan, your surviving Dependent Child(ren), including your biological child *in utero*, also may be covered if they meet the Dependent eligibility requirements. If your surviving Spouse/Domestic Partner works full time or is retired, he or she must enroll your child(ren) in any employer-sponsored health coverage for which they are eligible (including from a former employer).

Vested Participants in the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan

If you were hired prior to January 1, 2008, and were a vested participant in the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan, your surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow or UCC retiree medical summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center.

Vested Participants of the Rohm and Haas Company Retirement Plan

If you were hired prior to January 1, 2003 and were a vested participant who met the "Rule of 65" requirements in the Rohm and Haas Company Retirement Plan, your surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program. Refer to the Rohm and Haas Company Retirement Plan summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center.

Employees of Dow Corning Corporation Hired before January 1, 2017

If you were hired by Dow Corning Corporation before January 1, 2017, your surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow retiree medical summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center.

8.3 Surviving Children without Surviving Spouse/Domestic Partner

If there is no surviving Spouse/Domestic Partner, your surviving children who were eligible for coverage at the time of your death will be able to receive continued coverage for up to 36 months. This coverage meets the requirements of, and runs concurrently with, the coverage required under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Dow subsidizes the COBRA premiums for the first 12 months. Your surviving Dependent Children will be eligible for coverage under the Plan with premiums applicable to active Employees for up to one year after the date of your death. Thereafter, if they were covered for the first 12 months and paid the required premiums, they will be offered the remaining 24 months of coverage at COBRA rates – 102% of the full cost to insure. *In order to be covered, they must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

Surviving children of a Dow Corning Corporation employee hired before January 1, 2017 might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow retiree medical summary plan description for eligibility requirements for surviving children, or call the Retiree Service Center.

Section 9. Notices Required by Law

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Newborn's and Mother's Health Protection Act of 1996, and other federal legislation require notice of the following:

9.1 Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that the Program provide Participants notice that certain reconstructive surgery after a mastectomy is covered. While each Plan provided coverage for such surgery prior to the enactment of this law, this paragraph provides notice of your rights under the law. If a Participant receives benefits covered under the Plan in connection with a mastectomy and elects breast reconstruction, the Plan will provide coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, you may contact the Plan Administrator at the address or telephone number listed in *Section 1. ERISA Information*.

9.2 Maternity Stays

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Program or Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

9.3 Information Exchanged by the Program's Business Associates

Dow and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates, including, but not limited to the HMOs and insured plans under contract with Dow and the Plan Administrator. The Company may use aggregate data and summary health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with Dow and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA. See the Notice of Privacy Practices in the materials provided by your HMO or insurer.

Section 10. Fraud Against the Program

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

Section 11. Ending Coverage

11.1 When Coverage Ends

Except as otherwise provided in this Section 11.1, a Participant's coverage ends when any of the following occurs:

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

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

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

Generally, your Dependent's coverage under the Plan will terminate when your coverage terminates unless your Dependent:

- elects COBRA (See *Section 11.2 COBRA Continuation Coverage*); or
- is eligible to participate after your death in accordance with *Section 8. Survivor Benefits*.

11.2 COBRA Continuation Coverage

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

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

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

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

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

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
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.

As explained under *Section 11.2 COBRA Continuation Coverage*, although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners with comparable protection to Spouses for the qualifying events described above.

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

1. The parent-Employee 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 Program as a "Dependent Child."

When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or 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 your Domestic Partnership ends, you must provide the Plan Administrator with a valid "Termination of Domestic Partner Relationship" form within 60 days of the end of the Domestic Partnership.

If the qualifying event is a Dependent Child's loss of eligibility for coverage under a Plan, you must complete a Change in Status form that may be obtained from the Dow Benefits website 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/Domestic Partner, 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.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, your enrollment in Medicare (Part A, Part B, or both), your divorce or legal separation, or your Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage may continue for up to a total of 36 months. When the qualifying event is the end of employment or reduction of your hours of employment, COBRA continuation coverage may continue for up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage may be extended:

(1) Medicare Extension for Spouse and Dependent Children

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

(2) Disability Extension of 18-Month Period of Continuation Coverage

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

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

(3) Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

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 Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

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

How Much Does COBRA Continuation Coverage Cost?

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

First Payment of Continuation Coverage

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

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

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

Periodic Payments for Continuation Coverage

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

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

Grace Periods for Periodic Payments

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate Recipients under QMCSOs

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Keep the Program Informed of Address Changes

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

Section 12. Subrogation

The provisions of this Section 12 shall not be construed to limit or restrict in any way the subrogation or reimbursement provisions set forth in materials provided by your Plan. Any such provisions in materials provided by your insurer or HMO shall apply in addition to the provisions of this Section 12. In case of conflict between this Section 12 and materials provided by your insurer or HMO, the Plan Administrator shall have exclusive authority to determine which provisions will govern.

As used in this Section 12, these terms have the following meaning:

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

12.1 The Program's Entitlement to Reimbursement

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

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

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

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

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

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

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

12.2 Your Responsibilities

The Covered Person is required to fully cooperate with the Program's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Program, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Program may reasonably request. The rights described in this Section 12 are assigned to the Program without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Program an assignment and other instruments that may be used to facilitate securing the rights of the Program. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

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

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

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

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

12.3 Jurisdiction

For purposes of this Section 12, by accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Program may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Section 13. Your Legal Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Program, including insurance

contracts and collective bargaining agreements (if applicable), and the Plan Document, and the latest annual report filed (Form 5500 Series) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (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 or your Dependents must pay for such coverage. For more information, see *Section 11.2 COBRA Continuation Coverage*.

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Program fiduciaries misuse the Program's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. For more information regarding enforcing your rights in court, see *Section 18. Litigation and Class Action Lawsuits*.

Assistance with your questions: If you have any questions about the information in this SPD or an eligibility for coverage question, you should contact the Plan Administrator. If you have a question about the benefits covered, or the terms and conditions for receiving benefits, network providers, etc., you should contact the HMO Network Manager or the applicable Plan. For the contact information for the Plan Administrator, the HMO Network Manager and the applicable Plan, see *Section 1. ERISA Information*.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Section 14. Plan Administrator's Discretion

The Plan Administrators are the Global Benefits Director and the 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 *Section 25. Claims Procedures.*

Section 15. Plan Document

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

Section 16. No Government Guarantee of Welfare Benefits

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

Section 17. Dow's Right to Terminate or Amend the Program

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

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

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

Section 18. Litigation and Class Action Lawsuits

18.1 Litigation

If you wish to file a lawsuit against the Program or the Plan (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures

described in *Section 25. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA. (A lawsuit against the Plan is considered a lawsuit against the Program of which the Plan is a part, for purposes of this SPD.)

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

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

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

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

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

18.2 Class Action Lawsuits

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

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

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

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

Section 19. Incompetent and Deceased Participants

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

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

Section 20. Privilege

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

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

Section 21. Waivers

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

Section 22. Providing Notice to Administrator

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

Section 23. Funding

Dow and Participating Employers share the premium costs with Employees. Employee contributions are generally made through payroll deduction. Benefits are underwritten by the applicable Plan. The Program is an insured plan under ERISA.

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

Section 24. Payment of Unauthorized Benefits

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

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

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

Section 25. Claims Procedures

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

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

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation. See the materials provided by the HMO or insurer of your Plan describing the benefits it provides for procedures governing Claims for Plan Benefits. See *Section 25.4 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

25.1 Deadline to File a Claim

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

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

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

- *Claims for Plan Benefits.* The Initial Claims Reviewer and the Appeals Administrator is the HMO or insurer of your Plan.
- *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.

Authority of Claims Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. However, the Claims Administrators' determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Program under Section 502 of the Employee Retirement Income Security Act (ERISA) in federal court, provided you complete the claims procedures described in this *Section 25. Claims Procedures* (or the Claims Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *Section 18.1 Litigation* for the deadline for filing a lawsuit.

25.3 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 Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program. As described in the materials provided by your HMO or insurer, in the case of a Claim for Plan Benefits that is an Urgent Care Claim, a health care professional with knowledge of your condition also may act as your authorized representative.

25.4 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

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

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

Claims for an Eligibility Determination must be sent to:

Human Resources Operations Compensation and Benefits Manager
The Dow Chemical Company

North America Benefits
P.O. Box 2169
Midland, Michigan 48641
Attention: Initial Claims Reviewer for The Dow Chemical Company Insured Health Program (Appeal of Eligibility Determination)

Initial Determination

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

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

Appealing the Initial Determination

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

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

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

North America Health and Insurance Plan Manager or the North America Health and Insurance Plans Leader
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, Michigan 48641
Attention: Appeals Administrator for The Dow Chemical Company Insured Health Program (Claim for Eligibility Determination)

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

After the Appeals Administrator receives your written request to appeal the initial determination, the Appeals Administrator will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The Appeals Administrator is not the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. The Appeals Administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days of the written request for appellate review, except that under special circumstances, the Appeals Administrator can have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator needs such an extension, it will notify you prior to the expiration of the initial 60-day period, state the reason why such an extension is needed, and indicate when it will make its determination. If an extension is needed because the Appeals Administrator determines that it does not have sufficient information to make a decision on the Claim, it will describe any additional material or information necessary to submit to the Program, and provide you with the deadline for submitting such information.

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

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

Section 26. Tax Consequences of Coverage and Benefits

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

Section 27. 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 Program shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or change of any kind. You may direct that benefits payable to you be paid instead to a provider or to a person who has agreed to pay for any benefits payable under the Program. The Program reserves the right to make payment directly to you, however.

Section 28. Definitions of Terms

The following are some of the defined terms of the Program. Additional terms are defined in the Plan Document for the Program and the materials provided by your HMO or insurer describing the benefits it provides. A copy of the Plan Document is available upon request of the Plan Administrator at the contact information provided in *Section 1. ERISA Information*.

Active Employee Points

The sum of the Employee's age and years of service recognized under the Company's service award policy.

Appeals Administrator

The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is the applicable HMO or insurer for the Plan. The Appeals Administrators with respect to reviewing an adverse Claim for

an Eligibility Determination are the North America Health and Insurance Plan Manager and the North America Health and Insurance Plans Leader.

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

Claim
A written request by a claimant for a Plan benefit, or for an eligibility determination, that contains, at a minimum, the information described in *Section 25. Claims Procedures*.

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

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

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

COBRA
The federal law (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) that allows a Participant to stay enrolled in the Program for a limited time after coverage for that person would ordinarily cease. Some states have similar statutes that apply to the Plans that do business in those states.

Company
The Dow Chemical Company.

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

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

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

In addition to meeting the above requirements, in order to be eligible for coverage, the Dependent Child must not be excluded for one of the reasons described in *Dependent Child(ren) Exclusions* under Section 4.3.

Domestic Partner

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

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

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

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

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

Dow

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

Employee

A person who:

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

- if on international assignment, is either a U.S. citizen or Localized in the U.S.

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

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

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

Full-Time
Classified by the Participating Employer as having Full-Time status.

Highly Compensated Employee
Any person who is a "highly compensated employee" as such term is defined in section 414(q) of the Internal Revenue Code.

HIPAA
The Health Insurance Portability and Accountability Act.

HMO
Health Maintenance Organization.

Initial Claims Reviewer
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the applicable HMO or insurer for the Plan. The Initial Claims Reviewers with respect to deciding a Claim for an Eligibility Determination are the Human Resources Operations Compensation and Benefits Manager and the North America Health and Insurance Subject Matter Expert.

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

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

LTD Participant
A former Employee who is receiving a long term disability payment from The Dow Chemical Company Long Term Disability Program who meets the eligibility requirements for the Program, is enrolled in coverage under the Program, and remains eligible for benefits under the Program.

Married or Marriage
A civil contract between two individuals who have the legal capacity to marry and that is formalized by a marriage license. Whether a person is "Married" for purposes of the Program shall be determined in accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue Service and the Department of Labor. For periods before September 16, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Program then in effect. The Program does not recognize common law marriages except that:

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

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

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

Participating Employer
The Company or one of its subsidiaries that has been authorized by the Company to participate in the Program. "Participating Employers" and "Dow" have the same meaning and are used interchangeably. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan
The Plan that provides coverage from an HMO or insurer under the Program, except The Dow Chemical Company International Medical and Dental Plan.

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

Plan Document
The plan document for the Program, which is ERISA Plan #601. The summary plan descriptions for the HMOs or insured plans offered under the Program are integral parts of the Plan Document.

Program
The Dow Chemical Company Insured Health Program.

QMCSO
A QMCSO is a "Qualified Medical Child Support Order." This is a court order that gives a child the right to be covered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent. You can obtain a free copy of the Program's QMCSO procedures, which explain how the Program determines whether a court order meets the Program's requirements by requesting a copy from the Plan Administrator at the contact information listed in *Section 1. ERISA Information*.

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

"Rohm and Haas" (or "ROH")
Rohm and Haas Company and certain of its subsidiaries.

Salaried
Not represented by a collective bargaining unit.

Spouse
A person who is Married to an Employee (or other individual eligible for coverage under Section 4.2 of this SPD). See the definition of Marriage for further details.

Summary Plan Description ("SPD")
The summary plan description for the Program, which includes materials provided by the applicable Plan. The Summary Plan Description is an integral part of the Plan Document.

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

UCC or Union Carbide
Union Carbide Corporation and certain of its subsidiaries.

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

Section 29. For More Information

For more information regarding the provisions in this SPD, please contact the Dow HR Services Center using the contact information in *Section 1. ERISA Information*.

IMPORTANT NOTE

This SPD Wrapper, together with the materials provided by the applicable Plan, is intended to constitute the "Summary Plan Description" ("SPD") for the Plan, provided under The Dow Chemical Company Insured Health Program ("Program") applicable to eligible active Employees. However, this booklet is not all-inclusive and it is not intended to take the place of the Program's legal documents.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and any

underlying insured plan or HMO) at any time in its sole discretion.

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

APPENDIX A Important Notice of Creditable Coverage for Medicare-Eligibles

Applicable to Plan Year 2017

The Dow Chemical Company Insured Health Program *does* provide *Creditable* Coverage for prescription drugs for the following plans:

- **Triple S Plan**
- **All health maintenance organizations (HMOs) participating in The Dow Chemical Company Insured Health Program that are available for those who are not eligible for Medicare ("Dow-approved HMOs")**

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Dow coverage, be aware that you and your dependents will be able to enroll in The Dow Chemical Company Insured Health Program during Dow's annual enrollment period.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	Spring, 2016
Name of Entity/Sender:	The Dow Chemical Company
Contact--Position/Office:	North America Benefits
Address:	P.O. Box 2169
	Midland, MI 48641
Phone Number:	(800)-344-0661

APPENDIX B CHIP Premium Assistance Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website:http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**

Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website:http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of

information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2016)