Summary Plan Description "Wrapper" for:

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

Rohm and Haas Insured Health Program

(ERISA Plan #551)

APPLICABLE TO ELIGIBLE RETIREES

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Effective January 1, 2014 and thereafter until superseded

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

Content Steward: Theis
January 1, 2014
Literature # 318-60936

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Section 1. ERISA Information

Summary Plan Description for Rohm and Haas Company Insured Health Program, applicable to Eligible Retirees	
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 Employee Development Center Midland, Michigan 48674
Employer Identification Number:	38-1285128
Plan Number:	551
Plan Administrator:	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661
Retiree Service Center	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661 or
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:* North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661 *To appeal a denied Claim for an Eligibility Determination:* Associate Director of North America Benefits /Global Benefits Director The Dow Chemical Company Employee Development Center Midland, Michigan 48674

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	Towers Watson BenefitConnect COBRA Service Center P.O. Box 919051 San Diego, CA 92191-9863 (877) 292-6272
HMO Network Manager	Secova is the HMO Network Manager for HMOs offered to Retirees and their Dependents. Secova, Inc. 535 Anton Boulevard, Suite 900 Costa Mesa, California 92626 (800) 7DOWDOW or (800) 858-4347
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	The Company shares the premium costs with Retirees. The Company's share of the premium costs are limited to the retiree medical budget ("premium cap"). 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, can 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.

Retiree-Only Coverage	The Rohm and Haas Company Health and Welfare Plan Retiree Insured Health Program does not cover any active employees. Accordingly, Plan coverage provided under the Program is not subject to (i) the special enrollment, pre-existing condition, and nondiscrimination requirements (other than those relating to GINA) of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); (ii) the Women's Health and Cancer Rights Act of 1998, as amended, with respect to post-mastectomy reconstructive surgery; (iii) the Mental Health Parity Act of 1996, as amended, or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, with respect to mental health benefits; or (iv) the coverage mandates and prohibitions for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA").

Section 2. Introduction to SPD Wrapper

This is the Summary Plan Description "Wrapper" ("SPD Wrapper") for Health Maintenance Organizations ("HMOs") and insured health plans offered under the Rohm and Haas Company Health and Welfare Plan Insured Health Program (the "Program"). The Program is one of the components of the Rohm and Haas Company Health and Welfare Plan. In this SPD Wrapper, the HMOs and insured plans offered by the Program are referred to collectively as the "Plans" and individually as a "Plan."

The HMOs and insured plans offered by the Program are listed each Fall in the annual enrollment materials. This SPD Wrapper addresses:

- ERISA Information
- Eligibility for Coverage
- Enrollment
- Mid-Year Election Changes
- Premiums
- Survivor Benefits
- Disclosures
- 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 Rohm and Haas Health and Welfare Plan, as well as in materials provided to you by the applicable Plan. The materials provided by the Plans address the following:

- Benefits covered under the applicable Plan and the coverage levels
- 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
- Any other provisions of the applicable Plan
- HIPAA notice of privacy practices

This SPD Wrapper, together with the materials provided by the applicable Plan, are intended to 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 in *Section 1. ERISA Information*.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and/or its inclusion or exclusion of any HMO or insured plan) 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 Rohm and Haas Company Insured Health Program. For more information about other Dow-sponsored plans for which you may be eligible, check www.dowfriends.com or call the Retiree Service Center at (800) 344-0661.

Capitalized words in this SPD are defined in the Plan Document, in *Section 29. 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.

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.

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 12.2 COBRA Continuation Coverage* for details, or contact the Retiree 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 Secova (at the contact information listed in *Section 3.4 Secova, the HMO Network Manager*).

3.2 Rohm and Haas, 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 or Rohm and Haas, 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 and Rohm and Haas. 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 or Insurer 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 Secova, the HMO Network Manager

The Company has contracted with Secova, 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 Secova at (800) 7DOWDOW. Secova will also assist you in obtaining HMO materials if you need help getting them from the HMO.

3.5 Medicare Advantage Plans

The Plans offered under the Program that are available to those who are eligible for Medicare are HMOs or insured plans that have been approved by the government as "Medicare Advantage Plans with Prescription Drug Coverage" and are "Medicare Advantage Plans." If enrolling in a Medicare Advantage Plan, you must be enrolled in Medicare Parts A and B.

3.6 Grandfathered HMOs

Dow believes that certain HMOs offered under the Program may be "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 the Retiree Service Center. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa.

Section 4. Eligibility

As explained in this section of the SPD, the Program provides coverage for certain Retirees and disabled individuals, as well as certain dependents. Survivor eligibility is summarized in *Section 9. Survivor Benefits*.

4.1 PlanAvailability

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 6.6 If You Move out of the Plan Covered Location During the Plan Year*.

Note that the Aetna Medicare Advantage PPO is available nationwide. In addition, some Plans do not provide coverage to Medicare eligible individuals.

4.2 Eligibility for Retirees and LTD Participants

Retirees

The Program is applicable to eligible Retirees. "Retiree" is defined in *Section 29. Definitions of Terms*. You are not eligible for coverage if you were hired by a Participating Employer on or after January 1, 2003.

The Program is not applicable to you if you retired under the terms of the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan. Instead, refer to the summary plan descriptions for the Dow Retiree Medical Care Program or the Union Carbide Retiree Medical Care Program.

If you are a Retiree, you are eligible for coverage under the Program only if you are not eligible for coverage as an employee or retiree under another medical program or retiree medical support program sponsored by Dow or any entity that is 50% or more owned by Dow (other than the Rohm and Haas Retiree Medical Care Program).

Long Term Disability Participants

Certain disabled individuals are eligible for coverage under the Program. In general, to the extent that you are eligible for coverage under the Program as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as a Retiree. Unless the context requires otherwise, references to "Retiree" in this SPD include LTD Participants described below.

If you are eligible to participate in the Rohm and Haas Company Retirement Plan and you have been approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), your eligibility for coverage under the Program begins when your LTD benefit payments begin, and the following rules apply:

- If you were hired by Rohm and Haas before January 1, 2003, and you have ten (10) or more years of Service, you are eligible for coverage under the Program until you are no longer eligible to receive payments from LTD. You must pay the same premium active Employees pay. If you die while you are still receiving LTD payments, your Surviving Spouse of Record/Domestic Partner of Record is eligible for coverage as a Retiree if at the time of your death you were at least age 50 and you had combined age and service of at least 65 Points. The rules that apply to your Surviving Spouse of Record/Domestic Partner of Record's participation in the Program are the same as those that apply to a Surviving Spouse of Record/Domestic Partner of Record of a deceased Retiree (described in *Section 9.2 Surviving Spouse of Record/Domestic Partner of Record of a Deceased Retiree*).
- If you were hired by Rohm and Haas on or after January 1, 2003, or you have less than ten (10) years of Service, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends before the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have one (1) year of Service or more.
    - During the 12- or 24-month period (as applicable), you will be required to pay the same premiums active Employees pay.
    - If you die while you are still eligible for the 12- or 24-month period of medical coverage, your Surviving Spouse of Record/Domestic Partner of Record may continue coverage at the active Employee premium for the remainder of the 12- or 24-month period, whichever is applicable.

- After the expiration of the remainder of the 12- or 24-month period, your Surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules.

You are not eligible for coverage under the Program or under the Rohm and Haas Retiree Medical Care Program if you receive benefit payments from the LTD and you are a vested participant of the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan. Instead, refer to the summary plan description for the Dow Retiree Medical Care Program or the Union Carbide Retiree Medical Care Program, as applicable.

4.3 Dependent Eligibility

Eligible Retirees (and eligible LTD Participants) can enroll their eligible Dependents. A Dependent may be either your Spouse of Record or your Domestic Partner of Record, or an eligible Dependent Child. You must be enrolled in order to enroll a Spouse of Record/Domestic Partner of Record or Dependent Child. If you enroll your Spouse of Record/Domestic Partner of Record or your Dependent Child, you may be required to provide their Social Security numbers to the Plan.

The Program reserves the right at any time to request 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 of Record/Domestic Partner of Record

Your Spouse of Record/Domestic Partner of Record is determined as follows:

- If you were eligible for coverage under the Program before January 1, 2011, your Spouse of Record or Domestic Partner of Record is your Spouse or Domestic Partner before January 1, 2011, to whom you remain Married or with whom you remain in a Domestic Partnership on and after January 1, 2011.
- If you became eligible for coverage under the Program on or after January 1, 2011, your Spouse of Record or Domestic Partner of Record is your Spouse or Domestic Partner as of your last day on the payroll to whom you remain Married or with whom you remain in a Domestic Partnership.

If you marry, remarry or enter into a new Domestic Partnership after Retirement (or after December 31, 2010, if you were eligible for coverage under the Program before January 1, 2011), your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow sponsored retiree medical program.

However, if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married. Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement (or after December 31, 2010) and the exception described in the preceding sentence does not apply, your new Spouse's or Domestic Partner's children (e.g., your step-children) that are not your birth or legally adopted children are not generally eligible for coverage under any Dow-sponsored retiree medical program.

Spouse of Record/Domestic Partner of Record Exclusions

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

- Eligible for coverage as a full-time employee or retiree under another employer's plan, but not enrolled for personal coverage in that plan.[1] See *Working or Retired Spouse of Record/Domestic Partner of Record Rule*, immediately below;
- An Employee or enrolled for coverage as an Employee or Retiree (or other former Employee) under another Dow, or Dow-affiliated medical plan (see *Section 6.5 Dual Dow or UCC Coverage*); or
- Serving in the armed forces of any country.

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

Working or Retired Spouse of Record/Domestic Partner of Record Rule

If your Spouse of Record/Domestic Partner of Record (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 of Record/Domestic Partner of Record's employer is or what the premiums are. If your Spouse of Record/Domestic Partner of Record's employer offers more than one type of health coverage (e.g., more than one group health plan), your Spouse of Record/Domestic Partner of Record must enroll in the coverage that is most comparable to the Plan in which you are enrolled.

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

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

- If your Spouse of Record/Domestic Partner of Record fails to enroll in appropriate coverage available through his or her own employer (or former employer):

    - 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 of Record/Domestic Partner of Record was enrolled in the Plan and failed to enroll in his or her own employer's coverage.
    - 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 of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer), the Program may cancel coverage for you and/or your Spouse of

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

Record/Domestic Partner of Record retroactive to the first day that your Spouse of Record/Domestic Partner of Record 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 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.

- If you pay 102% of the full cost of coverage but you do not provide proof that your Spouse of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer or in Medicare by the date determined by the Plan Administrator, coverage will terminate as of the date that the Program learns that your Spouse of Record/Domestic Partner of Record failed to enroll in the employer coverage.
- 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 of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer, your Spouse of Record/Domestic Partner of Record will remain covered under the Plan for the Plan Year.

Additional or alternative actions might be taken on account of your or your Spouse of Record/Domestic Partner of Record's fraudulent actions or inactions or intentional misrepresentation. See *Section 11. Fraud Against the Program*.

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

Waiving Coverage – Working Spouse of Record/Domestic Partner of Record

You should consider carefully whether it is advantageous to enroll your Spouse of Record/Domestic Partner of Record as a Dependent under the Program if the coverage offered by his or her employer is as comprehensive as or better than the Program's. Any Plan in which you enroll your Spouse of Record/Domestic Partner of Record under the Program would be secondary to your Spouse of Record's/Domestic Partner of Record's medical plan under the Dow coordination of benefits rules, as explained in *Working or Retired Spouse of Record/Domestic Partner of Record Rule*, above. You may choose to waive coverage for your Spouse of Record/Domestic Partner of Record 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 of Record's or Domestic Partner of Record's natural or adopted child; or
- a child for whom you or your Spouse of Record/Domestic Partner of Record have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two

bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently "legally relinquished all of their parental rights" in a court of law. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:

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

Notwithstanding the foregoing paragraph, for heritage Morton dependents, the definition of "Dependent" child also includes a grandchild whom a Retiree enrolled as a dependent in the Morton Retiree Medical Program before July 1, 2000 and who (a) has remained continuously enrolled in a retiree medical plan offered through the Rohm and Haas Company Health and Welfare Plan since that date; (b) depends on the Retiree for his or her total support; and (c) has not reached age 19, or has reached age 19 but is a Full-Time Student and has not reached age 25.

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

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

Dependent Child(ren) Exclusions

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

- *Reaches age 26.* Coverage ends on the child's 26th birthday. 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 Retiree 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 must make a new enrollment within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs. For information about rights your child may have for continuation of coverage under the Program as provided

by the federal COBRA law, see *Section 12.2 COBRA Continuation Coverage*. Note: In order for your Dependent to receive COBRA continuation coverage, you must provide notice that your child is no longer an eligible Dependent within 60 days after your Dependent becomes ineligible.

Eligibility through a Qualified Medical Child Support Order

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

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

- The name and last known mailing address of each child for whom the Retiree (or other Participant) 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 Retiree or custodial parent, the Program reserves the right to require the Retiree (or other Participant) 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*.

4.4 International Medical and Dental Plan Exclusion

Expatriates and their eligible Dependents should refer to the summary plan description for the Dow Chemical Company International Medical and Dental Plan to determine their eligibility and coverage under that plan. Those who are eligible for coverage under the Dow Chemical Company International Medical and Dental Plan are not eligible for coverage under the Program.

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. 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 26. Claims Procedures*.

Section 5. Medicare

5.1 Medicare Eligibility May Result in Changes or Loss in Coverage under the Program

Some HMOs do not provide coverage for persons who are Eligible for Medicare.

In addition, some HMOs do not provide coverage to families in which one member is Medicare-eligible and another is not. If you are enrolled in one of these HMOs and you or one or more of your Dependents becomes Eligible for Medicare, you will not be able to continue HMO coverage; you will need to change your coverage to a self-insured plan offered under the Rohm and Haas Retiree Medical Care Program.

5.2 Medicare Enrollment

If You Become Eligible for Medicare Parts A and B After You Retire

In general, if you are not yet Eligible for Medicare, you must enroll in Medicare Parts A and B ***during the three month period before you reach age 65*** in order to continue receiving benefits under the Plan. If you become Eligible for Medicare earlier than age 65 (e.g., due to disability), you must enroll in Medicare parts A and B within the deadlines set by Medicare or you may also enroll in a Dow-approved Medicare Advantage Plan.

Similarly, if your Spouse of Record/Domestic Partner of Record is becoming Eligible for Medicare, he or she must enroll in Medicare Parts A and B ***during the three month period before he or she reaches age 65*** (or by the deadline set by Medicare including for enrollment upon disability) in order to continue receiving benefits under the Plan.

Once enrolled in Medicare, you may be eligible for reduced premiums under the Program. To do so, you must contact the Retiree Service Center promptly to inform Dow of the Medicare enrollment.

If You Retire At or After You Reach Medicare Eligibility Age

- If you become a Participant when you reach age 65, you must enroll in both Parts A and B of Medicare ***during the three month period before you reach age 65***.
- If you become a Participant after reaching age 65, you should enroll in Medicare Part A during the three month period before you reach age 65, and in Medicare Part B during the three-month period prior to your Retirement or termination of employment.
- You may enroll in a Dow Medicare Advantage Plan. A prerequisite to enrolling in a Medicare Advantage Plan is for you to enroll in Medicare Parts A and B.

Consequences of *Not* Enrolling in Medicare

If you do not enroll in Medicare Parts A and B according to these guidelines, your benefits under the Program will be reduced by the amount that would have been covered by Medicare Parts A and B if you had enrolled, as of the date you were first Eligible for Medicare. For details about Medicare, obtain a copy of Your Medicare Handbook from your local Social Security Office or the Health Care Finance Administration, or contact one of those offices with your questions.

Deadline to Notify the Plan Administrator of a Change in Medicare Eligibility

If you become eligible, or your Dependent becomes eligible for Medicare due to disability or for any other reason before you (or your Dependent) reach age 65, you (or your Dependent) must enroll in Medicare Parts A and B within the deadlines set by Medicare in order to continue to be eligible for coverage under the Program.

- If you notify the Plan Administrator within 31 days before the date you become eligible for Medicare, coverage and premiums under the Program will be adjusted effective as of the date of Medicare eligibility.
- If you notify the Plan Administrator within 90 days after becoming eligible for Medicare, coverage under the Program will be adjusted effective on the first day of the first month after the

Plan Administrator receives the notification and any change in premiums will be made as soon as practicable after the date of your notification to the Plan Administrator.

- If you do not notify the Plan Administrator within 90 days of becoming eligible for Medicare, coverage will be corrected to the date the Plan Administrator deems administratively feasible. You will be responsible for any difference in premium contributions. In addition, to the extent that the Program has paid any benefits primary to Medicare but should have paid secondary to Medicare, you will be responsible for reimbursing the Program for the amount of that overpayment, even though your premium may not change.

If you cease to be eligible for Medicare (e.g., because you qualified for Medicare as a result of a Social Security disability benefit and you are no longer disabled), you must notify the Plan Administrator of the change in eligibility within 90 days.

Section 6. Enrollment

6.1 Levels of Participation

The levels of participation available are:

- Individual Only
- Individual plus Spouse of Record
- Individual plus Domestic Partner of Record
- Individual plus Child(ren)
- Individual plus Spouse of Record and Child(ren)
- Individual plus Domestic Partner of Record plus Child(ren)

You must be enrolled in order to enroll your Spouse of Record/Domestic Partner of Record or Dependent Child. 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 a Blue Care Network or one of the MAP Plus plans. Exceptions apply if you and your covered Dependents are pre- and post-Medicare eligible. Contact the Retiree Service Center for more information.

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

6.2 Enrolling at Retirement

To enroll for Program coverage upon your Retirement, enroll within 31 days after your Retirement on the Dow Benefits web site or by calling the Retiree Service Center. If you do not enroll yourself and/or your eligible Dependents within 31 days after Retirement, you and/or they will not be covered. You will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 7. Mid-Year Election Changes*).

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

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

2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the 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 your Dependent was not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of the date your proof of Dependent eligibility was required by the Plan Administrator.
4. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility, your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11. Fraud Against the Program*.

6.3 Annual Enrollment

Annual enrollment is typically held during the last quarter of the year and is handled electronically. Subject to the eligibility rules and to the rules described in *Section 6.4 Re-enrolling After Waiving Coverage*, below, you may enroll for coverage, switch plans, or waive coverage at this time. If you wish to add a Dependent – either a Spouse of Record/Domestic Partner of Record or an eligible child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll.

Note: If you enroll or disenroll in a Medicare Advantage Plan (i.e., a Medicare HMO), your enrollment or disenrollment must be approved by the Centers for Medicare and Medicaid Services ("CMS"), which is the government agency that administers Medicare. Your election to enroll or disenroll in a Medicare HMO offered by Dow is not effective until the Medicare HMO has received approval from CMS. Until such approval by CMS is received by the Medicare HMO, the plan administrator of the Dow Plan may enroll you in an alternative option.

You must provide proof of Dependent eligibility no later than March 31st of the applicable Plan Year. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

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

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

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 your Dependent was not eligible for coverage.

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

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

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11. Fraud Against the Program*.

If your Spouse of Record is enrolled in a Plan, you may not dis-enroll your Spouse of Record in anticipation of a divorce. You are required to continue coverage for your Spouse of Record 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 of Record 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 12.2 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 of Record/Domestic Partner of Record Rule.

6.4 Re-enrolling After Waiving Coverage

If at any time you waive coverage, and you subsequently would like to enroll for coverage under the Program, you may do so during annual enrollment, and your enrollment will be subject to the following rules:

- You may enroll in coverage under the Program only if you meet the eligibility requirements and--
  - You submit proof at the time of enrollment of other health coverage provided through another employer or former employer, or proof of private individual coverage;
  - You submit proof of enrollment in Medicare Parts A and B or a Medicare Advantage Plan that provides prescription drug coverage; or
  - You were not Eligible for Medicare and were covered under the MAP Plus Option 2 High Deductible Plan for the two preceding years.
- If you do not have proof of other health coverage provided through another employer or former employer or proof of private individual coverage, you may enroll only in the MAP Plus Option 2 High Deductible Plan under the Retiree Medical Care Program (if you are not Eligible for Medicare and are otherwise eligible).

6.5 Dual Dow or UCC Coverage

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

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

- If you each enroll separately, your deductibles and out-of-pocket maximums will be calculated separately. (This rule also applies to divorced parents who are independently eligible for coverage.)

6.6 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 Dow-sponsored medical coverage that is available at the new location and for which you are eligible. If you want to continue receiving health coverage under a Dow-sponsored plan after you move, you must notify the Retiree Service Center within 90 days of your move. Your ability to switch coverage is subject to the rules in *Section 7. Mid-Year Election Changes*.

Section 7. Mid-Year Election Changes

You may **drop** a Dependent from coverage or waive coverage for yourself at any time, except in anticipation of a divorce (as required by the COBRA rules).

Otherwise, you may change your medical coverage level (e.g., enroll yourself or **add** a Dependent) mid-year only if you have a special enrollment event or a "change in status" AND you meet all of the consistency rules. The Program administers change in status events and the consistency rules the same way with respect to Domestic Partners of Record as Spouses of Record, 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.

Note: Your ability to enroll yourself or your Dependent in the Plan pursuant to these mid-year election change rules is subject to the eligibility rules for the Plans, see *Section 4. Eligibility*, as well as rules that apply if you attempt to re-enroll after waiving coverage under the Plan. See *Section 6.4 Re-enrolling After Waiving Coverage*.

7.1 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 Plans for you or your Dependent(s) (including your Spouse of Record/Domestic Partner of Record) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependent(s) 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 Plans, you or your eligible Dependent must enroll 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 Child 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 Child 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 7.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *Section 7.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 7.7 Deadline to Enroll for Mid-Year Changes*.

7.2 Change in Status

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

- Divorce, annulment or Termination of Domestic Partnership, or death of your Spouse of Record/Domestic Partner of Record
- Birth, adoption or placement for adoption, or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse of Record /Domestic Partner of Record or Dependent Child.
- A change in the place of residence or work of you or your Spouse of Record /Domestic Partner of Record or Dependent Child.
- Your Dependent satisfies or ceases to satisfy the definition for "Dependent Child."
- Your Spouse of Record/Domestic Partner of Record or Dependent Child gains eligibility for coverage under his or her employer's health plan.

7.3 Consistency Rule

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 of Record/Domestic Partner of Record, or your Dependent Child ***gaining or losing*** eligibility for coverage under either the Program or the parallel plan of your Spouse of Record/Domestic Partner of Record's or Dependent Child's employer.
2. The election change to the Program must ***correspond with*** that gain or loss of coverage.

7.4 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.
- ***Significant Cost or Coverage Changes*** – If your Spouse of Record/Domestic Partner of Record is covered by his or her employer's plan, which allows him or her to change his or her benefit plan election because of a significant change in cost or coverage under his or her employer's plan, such change in election may allow you to change your Dow election. If your Spouse of Record/Domestic Partner of Record's employer's enrollment period is different from Dow's, your

Spouse of Record /Domestic Partner of Record's election under his or her employer's plan may constitute a significant coverage change allowing you to change your Program election.

- ***Entitlement to Medicare or Medicaid*** **–** If you, your Spouse of Record/Domestic Partner of Record, or your 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.

7.5 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. See also *Section 6.4 Re-enrolling After Waiving Coverage*.

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

7.6 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 of Record/Domestic Partner of Record's or Dependent Child's employment, or any other form of proof the Plan Administrator deems appropriate. The Plan reserves the right to, at any time, request proof of eligibility.

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

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

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 11. Fraud Against the Program*.

Dropping a Dependent

You may drop a Dependent at any time (except in anticipation of a divorce, as required by the COBRA rules) by updating your enrollment information on the Dow Benefits web site or notifying the Retiree Service Center.

As explained in *Section 4.3 Dependent Eligibility*, if you or your Dependent is no longer eligible for coverage, you must update your enrollment information on the Dow Benefits web site or notify the Retiree Service Center; otherwise, you will continue to be obligated to pay premiums until the date the Retiree Service Center processes your updated enrollment information, coverage may be dropped retroactively, and you may be required to reimburse the Plan for any medical benefits it already paid.

7.7 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 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 you are not Medicare-eligible and:
  - 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 change in status or special enrollment 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.
- In all other cases, if you are Medicare-eligible and:
  - If the Plan Administrator receives your enrollment request within 31 days prior to the change in status or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date of the event.
  - If the Plan Administrator receives your enrollment request within 90 days after the change in status or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date the Plan Administrator receives your enrollment request.

Section 8. Premiums and Premium Cap

You and the Company share the premium costs for your medical coverage, according to the guidelines set forth in the Plan Document and summarized in this section of the SPD. (Certain former employees listed in the M400 Appendix of the Plan Document for the Rohm and Haas Company Health and Welfare Plan are not required to pay a premium for coverage.)[2]

8.1 Retiree Medical Budget (Maximum Company Subsidy or the "Premium Cap")

The Company has established a retiree medical budget. The Retiree Medical Budget is the maximum amount that the Company pays toward medical premiums. ***This budget affects premiums only, not benefit amounts paid for medical services. The Company may contribute less than the maximum set under the Retiree Medical Budget, in its sole discretion.***

Each fall, the Company publishes retiree medical premiums for the various retiree medical plans for the following year. These premiums will be affected by whether or not the Retiree Medical Budget will be exceeded in the coming year. ***In years after the Retiree Medical Budget is exceeded, your retiree medical premium will increase significantly.***

The Company allocates all of the Retiree Medical Budget first to the prescription drug portion of the Program, with any remaining portion of the Retiree Medical Budget allocated to the remainder of the Program.

[2] In addition, special rules apply for former union-represented employees (and/or their surviving spouses) who retired before April 1, 2009 from one of 10 Morton Salt plants (Fairport, OH; Grand Saline, TX; Hutchinson, KS; Manistee, MI; Marysville, MI; Perth Amboy, NJ; Rittman, OH; Silver Spring, NY; St. Louis, MO; Weeks Island, LA) and who at their retirement were covered under the Morton Retiree Health Care Plan for Collectively Bargained Employees. Contact the Retiree Service Center for more information.

The Retiree Medical Budget varies by retiree group. The following are the Company's Retiree Medical Budgets for each of the specified groups. The Company will not subsidize premiums at an amount higher than the amounts described for each group.

$8,333/$2,000 Retiree Medical Budget ("ROH cap")

Applicable to:

- Legacy Rohm and Haas Retirees (other than those who are listed in Listed in the M400 Appendix ("M400") to the Plan Document for the Rohm and Haas Company Health and Welfare Plan; those listed in M400 are not subject to a Retiree Medical Budget).
- Legacy Retirees of the chemicals business of Morton International, Inc.(except as otherwise provided in an applicable collective bargaining agreement) who retired after December 31, 2000.
- Legacy Retirees hired by CMP Technologies (formerly known as Rodel, Inc.) prior to January 1, 2003 who transferred to and retired from the chemicals business of Rohm and Haas Company.
- Legacy Retirees hired by non-CMP Technologies (formerly Shipley, Inc.) prior to January 1, 2003 who transferred to and retired from the chemicals business of Rohm and Haas Company.

Details about the Retiree Medical Budget:

The maximum annual amount the Company pays for premiums under the Program for a pre-Medicare eligible Retiree is $8,333 per person, up to a maximum of 3 persons per Retiree. The maximum amount the Company pays for premiums under the Program for a Medicare-eligible Retiree is $2,000 per person, up to a maximum of 2 persons per Retiree.

$1,620 Full Service Retiree Medical Budget ("Morton cap")

Applicable to:

- Morton International, Inc. Retirees (other than those who retired before January 1, 1993, who are not subject to a premium cap).
- Rohm and Haas retirees hired before January 1, 2003 who transferred to and retired from the Morton Salt business of Morton International, Inc.
- CMP Technologies (formerly Rodel, Inc.) retirees hired before January 1, 2003 who transferred to and retired from the Morton Salt business of Morton International, Inc.
- Non-CMP Technologies (formerly Shipley, Inc.) retirees hired before January 1, 2003 who transferred to and retired from the Morton Salt business of Morton International, Inc.

Details about the Retiree Medical Budget:

The maximum annual amount the Company pays for premiums under the Program (regardless of Medicare eligibility) varies based on your years of service. For example, the maximum annual amount the Company pays for premiums under the Program for someone who retired with 30 years of service is $1,620 per covered individual, up to maximum of two covered individuals (i.e., $3,240 per retiree); for someone with 10 years of service the maximum annual amount the Company pays for premiums under the Program is $540 per covered individual, up to maximum of two covered individuals (i.e., $1,080 per retiree).

$2,700/$2,000 Retiree Medical Budget (Shipley cap)

Applicable to:

- Legacy non-CMP Technologies (formerly Shipley, Inc.) Retirees.
- Legacy Rohm and Haas Retirees hired before January 1, 2003 who transferred to and retired from CMP Technologies (formerly Rodel, Inc.) or non-CMP Technologies (former Shipley, Inc.).
- Legacy non-CMP Technologies (formerly Shipley, Inc.) Retirees hired before January 1, 2003 and who transferred to and retired from CMP Technologies (former Rodel, Inc.).
- Legacy Morton Retirees hired before January 1, 2003 who transferred to and retired from CMP Technologies (formerly Rodel, Inc.) or non-CMP Technologies (formerly Shipley, Inc.).

Details about the Retiree Medical Budget:

The maximum annual amount the Company pays for premiums under the Program for a pre-Medicare eligible Retiree is 50% of the premium, up to $225 per month (per household). The maximum amount the Company pays for premiums under the Program for a Medicare-eligible Retiree is 50% of the premium up to $2,000 per covered individual per year (i.e., $2,000 for you and $2,000 for your eligible dependent, up to a maximum amount of $4,000 per retiree).

8.2 If Medicare is NOT the Primary Payer

In general, if you are enrolled in coverage under the Program and you are Eligible for Medicare, Medicare is the primary payer of benefits (and your coverage under the Program is secondary) – even if you have not enrolled in Medicare.

However, if Dow provides the primary coverage instead of Medicare, you will be required to pay the premiums applicable to pre-Medicare-eligible Retirees.

8.3 Premium Payments/Excess Premium Payments

If you are receiving a monthly pension payment from the Rohm and Haas Company Retirement Plan and your monthly premium amount is less than your monthly pension payment amount, the Plan requires that your premium be paid from a deduction from your monthly pension payment. If your monthly premium amount is equal to or greater than your monthly pension payment amount, then your premium will not be deducted from your pension payment, but you will be billed for the premium.

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

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

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

In addition, the provisions of

Section 25. Payment of Unauthorized Benefits may apply if benefits were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

Section 9. Survivor Benefits

9.1 Surviving Spouse/Domestic Partner of a Deceased Employee

In general, a Surviving Spouse/Domestic Partner of an active Employee is eligible for 36 months of COBRA coverage under the active employee medical plan, such as The Dow Chemical Company Medical Care Program, if he or she was covered under the active employee plan at the time of death. Refer to the summary plan description for the applicable active employee plan in which the Employee participated.

However, if a Surviving Spouse/Domestic Partner of an active Employee qualifies under the "Rule of 65" (*See Section 29. Definitions of Terms*, the Surviving Spouse/Domestic Partner is eligible for coverage under the Program. If the Surviving Spouse/Domestic Partner is under age 50 at the time of the active Employee's death, he or she will be offered benefits under the Program at active employee premium rates until he or she reaches age 50. At age 50, the Surviving Spouse/Domestic Partner is required to pay retiree premium rates as if he or she were a Retiree. Except for the premiums that a Surviving Spouse/Domestic Partner of an active Employee must pay, the same rules apply to a Surviving Spouse/Domestic Partner of an active Employee as those that apply to a Surviving Spouse of Record/Domestic Partner of Record of a deceased Retiree (described in *Section 9.2 Surviving Spouse of Record/Domestic Partner of Record of a Deceased Retiree*).

9.2 Surviving Spouse of Record/Domestic Partner of Record of a Deceased Retiree

In general, a Surviving Spouse of Record/Domestic Partner of Record of a deceased Retiree is eligible to continue coverage under the Program, subject to the following rules:

- Effective January 1, 2013, remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record from eligibility for coverage. However, a Surviving Spouse of Record/Domestic Partner of Record cannot cover a new spouse or domestic partner.
- The Surviving Spouse of Record/Domestic Partner of Record must pay the same premium as the premium the Retiree would pay.
- If the Surviving Spouse of Record/Domestic Partner of Record is employed full-time or is retired, and is eligible for employer-sponsored health coverage, he or she must enroll in that coverage in order to obtain coverage under the Program. See the **Error! Reference source not found.** under ection 4.2 of this SPD.
- A Surviving Spouse of Record/Domestic Partner of Record does not need to be enrolled at the time of death to be eligible. However, if the Surviving Spouse of Record/Domestic Partner of Record is covered under another health plan, he or she may be restricted in which plan under the Program he or she may enroll. See *Section 6.3 Annual Enrollment*.
- If a Surviving Spouse of Record/Domestic Partner of Record waives coverage at the time of the Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record may enroll for

coverage only during annual enrollment or if there is a change in status. See *Section 6.4 Re-enrolling After Waiving Coverage*.

9.3 Surviving Spouse of Record/Domestic Partner of Record of a Deceased LTD Participant

The rules that apply for the Surviving Spouse of Record/Domestic Partner of Record of a deceased LTD Participant are described under *Long Term Disability Participants*, in *Section 4.2 Eligibility for Retirees and LTD Participants* of this SPD.

9.4 Surviving Children

If a Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program, the surviving children of the Retiree (or LTD Participant), including biological children in utero, may also be covered. They must meet the Dependent eligibility requirements and pay the applicable premiums. If the Surviving Spouse of Record/Domestic Partner of Record works full-time or is retired, he or she must enroll the surviving children in employer-sponsored health coverage for which they are eligible (including from a former employer).

If there is no Surviving Spouse of Record/Domestic Partner of Record, surviving Dependent Children who were eligible for coverage at the time of the 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: surviving Dependent Children pay the premiums applicable to the Retiree (or LTD Participant). Thereafter, if the surviving Dependent Children 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, the surviving Dependent Children must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

Section 10. Notices

The following notices are prescribed under 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. ***The Plans are not subject to many of the legal requirements described in these notices***. See "Retiree Only Coverage" under *Section 1. ERISA Information*. However, to the extent provided in the applicable Appendix A, the Plans may have elected to voluntarily comply with these requirements.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires notice that certain reconstructive surgery after a mastectomy is covered to the extent required by law. While each Plan provided coverage for such surgery prior to the enactment of this law and may continue to provide this coverage despite being a retiree-only plan, this paragraph provides notice of 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*.

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 an insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Certificates of Coverage

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

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

Information Exchanged by the Program's Business Associates

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

Section 11. 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, the Program and/or Dow may 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 any of its subsidiaries or affiliates because of

a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 12. Ending Coverage

12.1 When Coverage Ends

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 Plan for claims paid by the Plan that under the terms of the Plan, you or your Dependent are required to reimburse the Plan
- 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 Retiree 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 and elect COBRA continuation coverage, your coverage terminates at the times described in *What is COBRA Continuation Coverage?*, below. Generally, your Dependent's coverage under the Plan will terminate when your coverage terminates unless your Dependent:

- elects COBRA (See *Section 12.2 COBRA Continuation Coverage*); or
- is eligible to participate after your death in accordance with *Section 9. Survivor Benefits*.

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

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

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

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
(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 of Record, 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 the Spouse of Record of a Retiree, you become a qualified beneficiary if you lose your coverage under the Program because of any of the following qualifying events:

(1) Your Spouse dies;

(2) Your Spouse enrolls in Medicare (Part A, Part B, or both); or

(3) You become divorced or legally separated from your Spouse.

As explained under *Section 12.2 COBRA Continuation Coverage*, although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners of Record with comparable protection to Spouses of Record for the qualifying events described above.

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

(1) The parent-Retiree dies;

(2) The parent-Retiree enrolls in Medicare (Part A, Part B, or both);

(3) The parents become divorced or legally separated; or

(4) The child stops being eligible for coverage under the Program as a "Dependent Child."

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

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 your death, commencement of a proceeding in bankruptcy, or your 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 web site or by requesting one from the Retiree 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 of Record/Domestic Partner of Record 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 of Record may elect continuation coverage, or only one of you. You may elect COBRA continuation coverage on behalf of your Spouse of Record, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

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

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

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% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage.

First Payment of Continuation Coverage

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

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

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

Periodic Payments for Continuation Coverage

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

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

Grace Periods for Periodic Payments

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate Recipients under QMCSOs

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

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 13. Subrogation

The provisions of this Section 13 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 13. In case of conflict between this Section 13 and materials provided by your insurer or HMO, the Plan Administrator shall have exclusive authority to determine which document will govern.

As used in this Section 13, 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 a 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.

13.1 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.

13.2 Your Responsibilities

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

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

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

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

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

13.3 Jurisdiction

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

Section 14. 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 with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report, the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.
- Continue health care coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents must pay for such coverage. For more information, see *Section 12.2 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 19. 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 HMO or insurer. For the contact information for the Plan Administrator, the HMO Network Manager and the applicable HMO or insurer, 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 15. Plan Administrator's Discretion

The Plan Administrators are the Vice President, Human Resources Center of Expertise; Global Benefits Director; Associate Director of North America Benefits; and North America Health and Welfare Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 26. Claims Procedures.*

Section 16. 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 17. 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 18. 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 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 19. Litigation and Class Action Lawsuits

19.1 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 26. 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.

19.2 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 20. 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 you 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 21. 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 Retiree, 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 Retiree, 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 22. 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 23. 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 24. Funding

The Company shares the premium costs with the Participants. Participant contributions are either deducted from pension benefits or paid separately by the Participant. Benefits are underwritten by the HMO or the insurer of 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 or under the Rohm and Haas Company Health and Welfare Plan, as the Program and the Rohm and Haas Company Health and Welfare Plan may be amended from time to time, as well as to pay for any expenses of the Program or the Rohm and Haas Company Health and Welfare Plan. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.

Section 25. 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, Dependent, 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, Dependent or other person under the Program may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant, Dependent 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/or Dependent 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 or Dependent 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 Dependent 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 Retiree or his estate.

Section 26. Claims Procedures

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

- A *Claim for Plan Benefits* is a Claim requesting that the applicable Plan pay for benefits covered under the applicable Plan.
- A *Claim for an Eligibility Determination* is a Claim requesting a determination as to whether a claimant is eligible to be a Participant under the applicable Plan or 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 for procedures governing Claims for Plan Benefits. You may contact Secova for assistance in obtaining the information regarding your Plan. See *Section 26.4 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

26.1 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.

26.2 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 Reviewer is the North America Health and Welfare Plans Leader, and the Appeals Administrators are the Global Benefits Director and the Associate Director of North America Benefits.

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 26. 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 19.1 Litigation* for the deadline for filing a lawsuit.

26.3 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim on behalf of a Participant. The Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program. 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.

26.4 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 Retiree and the name of the person (Retiree, Dependent, Survivor, as applicable) who is requesting the eligibility determination;
- The name of the plan for which the eligibility determination is being requested (Rohm and Haas Company Insured Health Care Program),
- If the eligibility determination is being requested for the Retiree's dependent:
    - a description of the relationship of the dependent to the Retiree (e.g., Spouse/Domestic Partner of record, Dependent Child, etc.);
    - documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility Determinations must be sent to:

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Initial Claims Reviewer for Rohm and Haas Company Retiree Insured Health Program (Claim for 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 Retiree and the name of the person (Retiree, Dependent, Survivor, as applicable) who is appealing the Administrator's decision;
- The name of the Plan (Rohm and Haas Company Insured Health Program);
- Reference to the initial determination; and
- An explanation of the reason why you are appealing the initial determination.

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

Associate Director of North America Benefits or the Global Benefits Director
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Appeals Administrator for Rohm and Haas 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 27. 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 or benefits. You or your Dependents shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

Section 28. 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 29. 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 in *Section 1. ERISA Information*.

Adjusted Years of Service
With respect to Eligible Employees who are actively employed by a Dow Entity on or after January 1, 2010, "Adjusted Years of Service" means the service recognized by the Rohm and Haas Company Retirement Plan for vesting purposes. For example, if under the Rohm and Haas Company Retirement Plan 25 years of service is recognized for vesting purposes, the Rohm and Haas Company Health and Welfare Plan shall recognize 25 Adjusted Years of Service.

Appeals Administrator:
The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is the applicable insurer or HMO for the Plan. The Appeals Administrators with respect to reviewing an adverse Claim for an Eligibility Determination are the Associate Director of North America Benefits and the Global Benefits Director.

Bargained-for Employee:
An Employee who is represented by a collective bargaining unit that is recognized by the Company or a 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 26. Claims Procedures*.

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

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

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

"CMPT" or "CMP Technologies"
Rohm and Haas Electronic Materials CMP Inc. (formerly known as Rodel, Inc.)

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

Company:
The Dow Chemical Company.

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

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

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

Morton Heritage dependents: A "Dependent" child is also a grandchild whom a Retiree had enrolled as a dependent in the Morton Retiree Medical Program before July 1, 2000 and who (a) has remained continuously enrolled since that date; (b) depends on the Retiree for his or her total support; and (c) has not reached age 19, or has reached age 19 but is a Full-Time Student and has not reached age 25.

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

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

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

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

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

Domestic Partner of Record:

With regard to a Retiree (or other Participant eligible for coverage under Section 4.2 of this SPD)--

- who was eligible for coverage under the Program on or after January 1, 2010 and through December 31, 2010: a person who was eligible for Domestic Partner benefits from the Program before January 1, 2011, and continues to be the former Employee's Domestic Partner on or after January 1, 2011. (In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted by the date required by the Plan Administrator.)
- who became eligible for coverage under the Program on or after January 1, 2011: a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. (In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.)

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

Dow:

The Dow Chemical Company.

Dow Entity:
A "participating employer" of either The Dow Chemical Company Retiree Medical Care Program, or the Union Carbide Corporation Retiree Medical Care Program or the Rohm and Haas Company Retiree Medical Care Program, as "participating employer" is defined by each of those respective programs.

Dow Medicare Advantage Plan
A plan that has been approved by the federal government as a "Medicare Advantage Plan with Prescription Drug Coverage" and is also offered under The Dow Chemical Company Insured Health Program.

Eligible Employee:
For the period on or after January 1, 2010, "Eligible Employee" means an Employee who: (1) was hired by a Participating Employer of the Rohm and Haas Company Health and Welfare Plan prior to January 1, 2003; (2) met the eligibility requirements of The Dow Chemical Medical Care Program on his last day of active employment with a participating employer of The Dow Chemical Company Medical Care Program; and (3) is a vested participant of the Rohm and Haas Company Retirement Plan. For the period before January 1, 2010, contact the Retiree Service Center or refer to the Plan Document.

Employee:
For the period before January 1, 2010, "Employee" means "Eligible Employee" as defined in the Plan Document before January 1, 2010. For the period on and after January 1, 2010, "Employee" is defined as a person who:

- is employed by a Dow Entity 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 Dow Entity directly from Dow's U.S. Payroll Department (or a vendor with whom Dow has contracted to perform the U.S. payroll function);
- does not receive compensation for services performed for the benefit of a Dow Entity from an entity that is not either Dow or a vendor with whom Dow has hired to perform the U.S. payroll function; and
- is classified by the Dow Entity as having "regular full-time" status.

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).

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 Reviewer with respect to deciding a Claim for an Eligibility Determination is the North America Health and Welfare Plans Leader.

LTD:
The Dow Chemical Company Long Term Disability Program (ERISA Plan #606).

LTD Participant:
A former Employee who is receiving a long term disability payment from LTD 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 Plan 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 Plan then in effect. The Plan does not recognize common law marriages except that (a) if an Employee or Retiree was a participant of the Group Health Plan before January 1, 2010, and had a common law spouse covered as a dependent under the Group Health Plan, then such common law spouse is deemed under the Program to be Married to the Retiree; and (b) the Plan recognizes a marriage which meets the requirements of Texas Family Code Annotated section 2.402.

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

Medicare Advantage Plan:
A plan that has been approved by the government as a "Medicare Advantage Plan with Prescription Drug Coverage."

"Medicare-eligible" or "Eligible for Medicare":
A person who is eligible for Medicare because he meets the Medicare age eligibility requirements (currently, age 65). For example if a Retiree is eligible for Medicare because of a non-age related reason, such as because of a disability or because of end stage renal disease, and the Retiree is not yet old enough to meet the Medicare age eligibility requirement, then such Retiree does not lose Dow retiree medical eligibility until he meets the Medicare age eligibility requirement.

Medicare Part D:
The section of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act") that provides for Medicare-approved prescription drug plans that are approved as specified in 45 CFR § 423.272. These prescription drug plans meet the minimum standards set forth by the Medicare Modernization Act. As referred to in this SPD, Medicare Part D does not refer to Medicare Advantage Plans that provide prescription drug coverage.

Medicare prescription drug plan:
A prescription drug plan that has been approved as specified in 45 CFR § 423.272. These prescription drug plans meet the minimum standards set forth by the Medicare Modernization Act. As referred to in this SPD, Medicare Part D does not refer to Medicare Advantage Plans that provide prescription drug coverage.

"Non-CMPT" or "Non-CMP Technologies":
The former Shipley, Inc. business entity that became a division of Rohm and Haas Electronic Materials LLC.

Participant:
A Retiree, LTD Participant, Survivor, Dependent or other individual who participates in the Program because he meets the eligibility criteria of the Program.

Participating Employer:
Rohm and Haas Company and each Employer that has joined the Program. "Participating Employers" and "Rohm and Haas" 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 Dow Chemical 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 Dow Chemical 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 HMO or insured product that provides coverage from the HMO or insurance carrier. There are many "Plans" offered through HMOs and insurance carriers under the Program.

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

Plan Document:
The plan document for the Rohm and Haas Company Health and Welfare Plan, ERISA Plan #551. The summary plan descriptions for the plans offered under the Program are integral parts of the Plan Document.

Program:
The Rohm and Haas Insured Health Program, which is a component of the Rohm and Haas Company Health and Welfare Plan.

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 Plan's requirements by requesting a copy from the Plan Administrator at the contact information listed in *Section 1. ERISA Information*.

Retiree:
A "Retiree" is a person who meets the requirements of one of the following paragraphs (1) through (7):

(1) Eligible Former Legacy Rohm and Haas Employees Retiring On or Before December 31, 2003 Who Meet Any of the Following Conditions:

1. "56/30 Employees." On or before December 31, 2003, the Employee (i) is credited with 30 or more aggregate Adjusted Years of Service, (ii) is Actively Employed by the Participating Employer on the date he attains age 56, and (iii) retires after attaining age 56 but before age 60.

2. "60/15 Employees." On or before December 31, 2003, the Employee (i) is credited with 15 or more aggregate Adjusted Years of Service, (ii) is Actively Employed by the Participating Employer on the date he attains age 60, and (iii) retires after attaining age 60.

3. "Grandfathered Employees." The Employee (I) retired on or before December 31, 2003, after attaining age 60, and (II) was at least 50 years of age while employed by a Participating Employer on or before the applicable date:

   (i) For Employees at the Bristol location employed on an hourly basis: May 10, 1988;

   (ii) For Employees at the Louisville Kentucky Plant location who are members of the Fireman and Oilman Union employed on an hourly basis: January 1, 1989;

   (iii) For Hourly Employees at the Texas location: hired before March 5, 1988 and age 50 by January 1, 1989; and

   (iv) For all other Employees: January 1, 1988.

(2) Eligible Former Morton Legacy Employees Retiring On or Before December 31, 2003 Who Meet the Following Conditions:

Eligible Former Legacy Morton Employees ("Morton Retirees") who retired on or before December 31, 2003 after attaining the age of 55 with five (5) Adjusted Years of Service. A "Morton Retiree" does not include an Eligible Employee who is subject to the terms of a collective bargaining agreement, except as specifically provided under the terms of the applicable collective bargaining agreement.

(3) Eligible Former Legacy Electronic Materials (non-CMPT) Employees ("Electronic Materials Retirees") Retiring On or Before December 31, 2003 Who Meet Any of the Following Conditions:

1. Electronic Materials Retirees who retired on or before December 31, 2003 after attaining the age of 65; or

2. Electronic Materials Retirees who retired on or before December 31, 2003 after attaining the age of 60 with ten (10) Adjusted Years of Service; or

3. Electronic Materials Retirees who retired on or before December 31, 2003 after attaining the age of 55 with fifteen (15) Adjusted Years of Service.

4. An "Electronic Materials Retiree" does not include an Eligible Employee who is subject to the terms of a collective bargaining agreement, except as specifically provided under the terms of the applicable collective bargaining agreement.

(4) Eligible Former Legacy Rohm and Haas Employees, Eligible Former Legacy Morton Employees, Eligible Former Legacy Electronic Materials (non-CMPT) Employees, or Eligible Former CMP Technologies Transferred Employees hired before January 1, 2003 (and those listed in subparagraph (IV)(c) below of this definition of "Retiree") who retired on or after January 1, 2004 but before April 1, 2009 who also meet the requirements of subparagraphs (a) or (b) below:

1. The Eligible Employee (i) has been credited with a minimum of 15 Adjusted Years of Service, and (ii) was Actively Employed on the date they attained age 60; or

2. The Eligible Employee (i) has been credited with a minimum of 25 Adjusted Years of Service, and (ii) was Actively Employed on the date they attained age 55.

Notwithstanding any provision to the contrary, unless otherwise provided in a collective bargaining agreement to which he is subject or otherwise provided in subparagraph (IV)(c) below of this definition of "Retiree", an Eligible Employee who does not meet the age and, as applicable, Adjusted Years of Service requirements of paragraphs (1) through (4) of this definition of "Retiree" when he initially terminates employment and is subsequently rehired after December 31, 2002, shall not be a Retiree. For example, if an Eligible Former Legacy Rohm and Haas Employee was hired before January 1, 2003, terminated employment with the Participating Employer before meeting the Adjusted Years of Service and age requirements for becoming a Retiree, and is rehired by a Participating Employer on or after January 1, 2003, he shall not become a Retiree, even if he is credited with service for other purposes, unless he is covered under a collective bargaining agreement that provides otherwise.

(5) Certain Involuntarily Terminated Employees.

An Eligible Employee who (a) was hired by a Participating Employer before January 1, 2003, (b) terminated by a Dow Entity, (c) receives a benefit under The Dow Chemical Company Transition Payment Program or the Union Carbide Corporation Transition Payment Program that makes available retiree medical benefits after signing a release, (d) meets the definition of "Rule of 65" for involuntarily terminated employees, and (e) is a vested participant of the Rohm and Haas Company Retirement Plan at Retirement shall be deemed a "Retiree;" provided that any collective bargaining agreement to which the Eligible Employee is subject allows such Eligible Employee to receive such retiree medical and/or dental benefits.

(6) Eligible Former Sauquoit Employees who were hired by Sauquoit prior to January 1, 2003 and their eligible survivors who receive pension benefits through Continental.

(7) Eligible Former Legacy Rohm and Haas Employees, Eligible Former Legacy Morton Employees, Eligible Former Legacy Electronic Materials (non-CMPT) Employees, or Eligible Former CMP Technologies Transferred Employees hired before January 1, 2003 (and those listed in subparagraph (IV)(c) below of this definition of "Retiree") and retiring on or after April 1, 2009 who meet the requirements of subparagraphs (a) or (b) below:

1. The Eligible Employee (i) has been credited with a minimum of 15 Adjusted Years of Service, (ii) was an active Employee of a Dow Entity who was eligible to participate in The Dow Chemical Company Medical Care Program on the date he attained age 60, (iii) is a vested participant of the Rohm and Haas Company Retirement Plan at Retirement; or

2. The Eligible Employee (i) has been credited with a minimum of 25 Adjusted Years of Service, (ii) was an active Employee of a Dow Entity who was eligible to participate in The Dow Chemical Company Medical Care Program on the date he attained age 55, and (iii) is a vested participant of the Rohm and Haas Company Retirement Plan at Retirement.

Notwithstanding any provision to the contrary, unless otherwise provided in a collective bargaining agreement to which he is subject or otherwise provided in subparagraph (IV)(c) below, an Eligible Employee who does not meet the age and, as applicable, Adjusted Years of Service requirements of paragraphs (1) through (4) of this definition of "Retiree" when he initially terminates employment from a Dow Entity and is subsequently rehired after December 31, 2002, shall not be a Retiree. For example, if an Eligible Former Legacy Rohm and Haas Employee (as defined in the preceding sentence) was hired before January 1, 2003, terminated employment with the Participating Employer before meeting the Adjusted Years of Service and age requirements for becoming an Eligible Retiree, and is rehired by a Participating Employer on or after January 1, 2003, he shall not become a Retiree, even if he is credited with service for other purposes, unless he is covered under a collective bargaining agreement that provides otherwise.

With respect to an Eligible Employee who was hired by a Participating Employer prior to January 1, 2003 who does not meet the age and Adjusted Years of Service requirements of this paragraph (7) at the time he ***transfers*** to a "participating employer" of either the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan (as "participating employer" is defined in each of those respective plans), the Program will deem the service such Eligible Employee accumulates while he is a full time active employee of a participating employer of the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan as Adjusted Years of Service under the Program (whichever pension plan is applicable); provided that (1) the transfer occurs on or after April 1, 2009; (2) no break in service occurred between January 1, 2003 and the transfer; and (3) the Eligible Employee is a vested participant in the Rohm and Haas Company Retirement Plan.

On October 1, 2009, Morton International, Inc. was acquired by K+S AKTIENGESELLSCHAFT, and Morton International, Inc. ceased to be a Participating Employer. For purposes of this paragraph (7), a Former Legacy Morton Employee who was an active Employee of Morton International, Inc. on September 30, 2009 and continued to be an active Employee of Morton International, Inc. on October 1, 2009, is not considered as "retiring" or "retired" or a "retiree" of a Participating Employer regardless of such Former Legacy Morton Employee's age and Adjusted Years of Service on September 30, 2009 or October 1, 2009; such a former Employee is not eligible for retiree medical benefits. Such a former Employee is not a Retiree, even if such former Employees is a vested participant of the Morton International, Inc. Pension Plan for Collectively Bargained Employees or the Rohm and Haas Company Retirement Plan.

For purposes of this definition of "Retiree":

(I) "*Eligible Former Legacy Morton Employee*" means any former Employee of a Morton International, Inc. location who was hired prior to January 1, 2003 retired while Morton International, Inc. was a Participating Employer, retired in good standing and who was, at the time of retirement, an Eligible Employee. Morton International, Inc. ceased to be a Participating Employer on September 30, 2009.

(II) "*Eligible Former Legacy Rohm and Haas Employee*" means any former Employee of a Rohm and Haas Company location who was hired prior to January 1, 2003; is a "retiree" as defined under the Rohm and Haas Company Retirement Plan; and, was at the time of retirement (as defined under the Rohm and Haas Company Retirement Plan), an Eligible Employee as defined in Article I of the Plan Document for the Rohm and Haas Company Health and Welfare Plan.

(III) "*Eligible Former Legacy Electronic Materials Employee*" means any former Employee of Rohm and Haas Electronic Materials, LLC; Rohm and Haas Electronic Materials, Microelectronic Technologies; Rohm and Haas Electronic Materials, Circuit Board Technologies; Rohm and Haas

Electronic Materials, Packaging and Finishing Technologies; or the former Shipley Company, LLC (collectively "Electronic Materials") who was hired prior to January 1, 2003; is a "retiree" as defined under the Rohm and Haas Company Retirement Plan; and, was, at the time of retirement (as defined under the Rohm and Haas Company Retirement Plan), an Eligible Employee as defined in Article I of the Plan Document for the Rohm and Haas Company Health and Welfare Plan.

(IV) "*Eligible Former CMP Technologies Transferred Employees*" means any former Eligible Employee of Rohm and Haas Electronic Materials, CMP Technologies ("CMP Technologies") (formerly Rodel, Inc.) who:

1. was hired by CMP Technologies before January 1, 2003 and subsequently transferred to one of the Participating Employer's other business units (Chemical, Salt or Electronic Materials other than CMP Technologies) on or after January 1, 2004 and is a "retiree" as defined under the Rohm and Haas Company Retirement Plan;
2. was hired by the Participating Employer's Chemical, Salt or Electronic Materials (other than CMP Technologies) business unit before January 1, 2003 and subsequently transferred to CMP Technologies on or after January 1, 2004 and is a "retiree" as defined under the Rohm and Haas Company Retirement Plan; or
3. was an individual listed in Article I, Appendix B of the Plan Document for the Rohm and Haas Company Health and Welfare Program (regarding "Eligible Former CMP Technologies Transferred Employees") as eligible for retiree medical under the Program if he or she is a "retiree" as defined under the Rohm and Haas Company Retirement Plan; and, at the time of retirement (as defined under the Rohm and Haas Company Retirement Plan) is an Eligible Employee.

Retiree Medical Budget:
The maximum amount of aggregate premium that the Company may pay in any single year. Dow may choose to subsidize retiree medical premiums below the Retiree Medical Budget.

Retires or Retirement:
The date a Retiree "Retires" as defined under the Rohm and Haas Company Retirement Plan.

ROH:
Rohm and Haas Company

Rohm and Haas Health and Welfare Plan:
The Rohm and Haas Company Health and Welfare Plan (ERISA Plan #551). The Rohm and Haas Company Health and Welfare Plan comprises several benefit programs, including the Group Health Plan. The Group Health Plan is comprised of several components, including the Program and the Retiree Medical Care Program.

Rohm and Haas:
Rohm and Haas Company or any other corporation or business entity the Company authorizes to participate in the Rohm and Haas Company Health and Welfare Plan with respect to its Employees. "Participating Employers" and "Rohm and Haas" have the same meaning and are used interchangeably.

Rule of 65:
With respect to Employees who are not collectively bargained, an Eligible Employee who is at least age 50, with combined age and Adjusted Years of Service equal to or greater than 65 as of the date of termination of employment or death qualifies under the Rule of 65 if: (1) he or she was hired by a Participating Employer before January 1, 2003; (2) terminated by Dow Entity under a severance program sponsored by the Company or Rohm and Haas or Union Carbide; and (3) signs a release satisfactory to the Company or Union Carbide. If an Eligible Employee is a collectively bargained employee, then the

Rule of 65 applies only if the collective bargaining agreement applicable to such employee provides for the Rule of 65.

In addition, a Surviving Spouse/Domestic Partner qualifies under the Rule of 65 if the Surviving Spouse/Domestic Partner survives an active Employee of a Dow Entity who, on the date of such active Employee's death: (1) is not collectively bargained; (2) is at least age 50, with combined age and Adjusted Years of Service equal to or greater than 65 as of the date of death; (3) was hired by a Participating Employer before January 1, 2003; and (4) was a vested participant of the Rohm and Haas Company Retirement Plan. If an Eligible Employee is a collectively bargained employee, then the Rule of 65 applies to the surviving Spouse/Domestic Partner only if the collective bargaining agreement applicable to such employee provides for the Rule of 65 with respect to surviving Spouses/Domestic Partners.

Service:
Service has the same meaning as Adjusted Years of Service.

Spouse:
A person who is married to an Employee, Retiree, LTD Participant, or other former Employee eligible for coverage under the Program. With regard to a Retiree, your Spouse must be your Spouse of Record in order to be eligible for coverage under the Program.

Spouse of Record:
With regard to a Retiree (or other Participant eligible for coverage under Section 4.2 of this SPD)--

- who was eligible for coverage under the Program before January 1, 2011: the person who was Married to the Retiree or LTD Participant before January 1, 2011, and continues to be Married to the Retiree or LTD Participant; or
- who became eligible for coverage under the Program on or after January 1, 2011: the person who was Married to the Retiree or LTD Participant on his or her last day on the payroll, and continues to be Married to the Retiree or LTD Participant.

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

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

Summary Plan Description ("SPD"):
The summary plan description ("SPD") for the applicable Plan that is offered through the Program. The SPD for each Plan is comprised of this SPD Wrapper and the written benefits descriptions provided by the applicable HMO or insured plan. Together, the SPD wrapper and the written benefits description provided by the HMO or insurance carrier comprise each Plan's SPD. The SPDs are an integral part of the Plan Document.

Surviving Spouse/Domestic Partner:
The widowed Spouse/Domestic Partner of an active Employee who was eligible to participate in The Dow Chemical Company Medical Care Program at the time of the death of the Employee.

Surviving Spouse of Record/Domestic Partner of Record:
The widowed Dependent Spouse of Record/Domestic Partner of Record of a Retiree who participated in the Program, if such Spouse of Record/Domestic Partner of Record was an eligible Dependent at the time of the death of such Retiree; provided that the deceased was a vested participant of the Rohm and Haas Company Retirement Plan.

Survivor:
A Surviving Spouse or Surviving Domestic Partner or Surviving Spouse of Record or Surviving Domestic Partner of Record.

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

VPHR

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

Section 30. For More Information

For more information regarding the provisions in this SPD Wrapper, please contact the Retiree Service Center using the contact information in *Section 1. ERISA Information*. For information about benefits covered under a specific Plan, or claims for Plan benefits, contact the specific Plan. If you need help in finding an address or phone number for your Plan, contact Secova.

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 Rohm and Haas Company Health and Welfare Plan Insured Health Program ("Program") applicable to eligible Retirees. The Program is one of the components of the Rohm and Haas Company Health and Welfare Plan. 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 at any time in its sole discretion.

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

APPENDIX A. Important Notice of Creditable Coverage for Medicare-Eligibles

Applicable to Plan Year 2014

The Rohm and Haas Insured Health Program *does* provide *Creditable* Coverage for prescription drugs for the following plans:

- Triple S
- Aetna Medicare Advantage PPO
- All health maintenance organizations (HMOs) participating in the Rohm and Haas Insured Health Program that are available for those who are not eligible for Medicare ("Dow-approved HMOs")
- All HMOs participating in the Rohm and Haas Corporation Insured Health Program that are available for those who are eligible for Medicare ("Medicare Advantage - D Plans"). These HMOs have entered into contracts with Medicare to provide Medicare benefits, and are thus Medicare plans.

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 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:

1. 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.
2. The Dow Chemical Company has determined that the prescription drug coverage offered by all Dow participating HMOs are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

APPENDIX B. CHIP Premium Assistance Notice

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

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

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

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

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

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

<table>
<tr><td>ALABAMA – Medicaid</td><td rowspan="3">COLORADO – Medicaid

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

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><td>IDAHO – Medicaid</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084</td></tr>
</table>

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

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

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

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

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