Summary Plan Description for:

The Dow Chemical Company Medical Care Program's and The Dow Chemical Company Retiree Medical Care Program's

Self-Funded HMO Plans

(ERISA Plan #501)

APPLICABLE TO ELIGIBLE ACTIVE EMPLOYEES & PRE-MEDICARE-ELIGIBLE RETIREES

Amended and Restated

Effective January 1, 2017 and thereafter until superseded

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

Copies of updated SPDs (including this SPD) are available at the Dow Family Health website (http://www.dowfamilyhealth.com) or by requesting a copy from the HR Service Center by calling 877-623-8079 (if you are an active employee) or by calling the Dow Retiree Service Center at 800-344-0661 (if you are a retiree), or by submitting your request through the Dow Benefits website's Message Center available at (http://dowbenefits.ehr.com).

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

Content Steward: Lance
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Section 1. ERISA Information

Summary Plan Description for The Dow Chemical Company Medical Care Program and The Dow Chemical Company Retiree Medical Care Program (collectively referred to as the "Program") Self-Funded HMO Plans	
Type of Plan	Group health plan
Type of Plan Administration	Self-insured benefits administered under contract with the applicable HMO
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
Employer Identification Number	38-1285128
Plan Number	501
Plan Administrator	North America Health and Insurance Plans Leader The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641 Attention: Self-Funded HMO *Active employees*: (877) 623-8079 *Retirees*: (800) 344-0661
Dow HR and Retiree Service Centers	Dow Benefits Service Center – Coverage Compliance P.O. Box 5807 Hopkins, MN 55343 *Active employees*: (877) 623-8079 *Retirees*: (800) 344-0661
Claims Administrators for Claims for Plan Benefits	*To submit a Claim for Plan Benefits, contact the applicable Self-Funded HMO administrator:* Blue Care Network PO Box 68767 Grand Rapids, MI 49516-8767 (800) 662-6667 www.mibcn.com

	Blue Cross/Blue Shield Michigan (Illinois) National Customer Service Center Mail Code B455 600 Lafayette East Detroit, MI 48226-2998 (800) 752-1455 www.bcbsmi.com CIGNA HealthCare PO Box 182223 Chattanooga, TN 37422 (800) 244-6224 www.myCIGNA.com HealthPartners Administrators, Inc. P.O. Box 1289 Minneapolis, MN 55440-1289 (952) 883-5000 or 1-800-883-2177 www.healthpartners.com Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601 (800) 448-6262 www.humana.com *To appeal a denied Claim for Plan Benefits contact the applicable administrator:* Blue Care Network Grievance and Appeals Unit Mail Code C248 P.O. Box 284 Southfield, MI 48086 Blue Cross/Blue Shield Michigan (Illinois) Grievance and Appeals Unit P.O. Box 2627 Detroit, MI 48231-2627 CIGNA Appeals Unit P.O. Box 188011 Chattanooga, TN 37422 Member Services Dept. HealthPartners Administrators, Inc. P.O. Box 1309 Minneapolis, MN 55440-13 Humana Grievance and Appeals P.O. Box 14546 Lexington, KY 40512-4546

Claims Administrator for Claims for an Eligibility Determination	*To submit a Claim for an Eligibility Determination:* Human Resources Operations Compensation and Benefits Manager / North America Health and Insurance Subject Matter Expert The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641 *Active employees*: (877) 623-8079 *Retirees*: (800) 344-0661 *To appeal a denied Claim for an Eligibility Determination:* North America Health and Insurance Plans Leader / North America Health and Insurance Plan Manager The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
To Serve Legal Process	General Counsel The Dow Chemical Company Global Dow Center 2211 H.H. Dow Way Midland, MI 48674 *Or, serve the applicable administrator*: Blue Care Network Service Company 20500 Civic Center Dr. Mail Code C 467 Southfield, MI 48076 Blue Cross/Blue Shield of Michigan (Illinois) 600 Lafayette East Detroit, MI 48226 CIGNA HealthCare Legal Division W-26B 900 Cottage Grove Road Hartford, CT 06152 HealthPartners Administrators, Inc. Sales Executive 8100 34th Ave. S. P.O. Box 1309 Minneapolis, MN 55440-1309 Attention: Law Department Humana 500 West Main St. Louisville, KY 40202

COBRA Administrator	Willis Towers Watson BenefitConnect COBRA Service Center P.O. Box 919051 San Diego, CA 92191-9863 (877) 292-6272
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	Participating Employers share the premium costs with Participants. Employee costs and Retiree costs are separately rated. Employee contributions are generally made through payroll deduction. Retiree contributions are either deducted from pension benefits or paid separately by the Participant. Benefits are paid from the Company's general assets. With respect to Participants of The Dow Chemical Company Retiree Medical Care Program, the Company's contribution to Program costs is limited to the contribution limits established in April 1994, and amended in July 2001, unless adjusted by the Company, and except as otherwise provided. The contribution limits are described in *Section 8. Retirees: Premiums and Premium Cap*. The assets of the Program, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.
EAP	Aetna Employee Assistance Program 151 Farmington Avenue Mailstop RS 32 Hartford, CT 06156
Retiree-Only Coverage	The Dow Chemical Company Retiree Medical Care Program does not cover any active employees. Accordingly, Plan coverage provided under The Dow Chemical Company Retiree Medical Care 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

This is the Summary Plan Description ("SPD") for the Self-Funded HMO Plans (the "Plans") offered under each of The Dow Chemical Company Medical Care Program and The Dow Chemical Company Retiree Medical Care Program (collectively referred to as the "Program") as applicable to eligible Employees, pre-Medicare-eligible Retirees, 60 Point Retiree Medical Severance Plan Participants, DCC Retirees, 65 Point Retiree Medical Severance Plan Participants, LTD Participants, DCC LTD Participants, and certain other former Employees.

The Plans have the same or similar plan design as an insured HMO, but the benefits are funded from Dow's general assets under a contract between Dow and the HMO. The Plans described in this SPD are:

- Blue Care Network Self-Funded HMO Plan
- Blue Cross/Blue Shield of Michigan (Illinois) Self-Funded HMO Plan
- CIGNA Self-Funded HMO Plan
- HealthPartners Self-Funded HMO Plan
- Humana Self-Funded HMO Plan

The Plans are governed by the plan documents for the Program, which are the legal instruments 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 Documents, the Plan Documents shall govern.

This SPD contains important information about benefits under the Plans. However, it does not contain all of the information. Further information can be found in the Plan Documents. You may request a copy of either of the Plan Documents from the Plan Administrator at the contact information listed under *Section 1. ERISA Information*.

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

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

The provisions of this SPD apply only to the Self-Funded HMO Plans. For information about other Dow-sponsored plans for which you may be eligible, check the Dow Intranet, www.dowfriends.com, or contact the:

- HR Service Center (for active Employees) at (877) 623-8079; or
- Retiree Service Center (for Retirees) at (800) 344-0661.

Capitalized words in this SPD are defined in the Plan Document, in *Section 30. Definitions of Terms*, in the applicable *Description of Plan Benefits (Appendix A)* for the specific Plan, or in the section where they are used.

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

About Appendix A (Description of Plan Benefits)

Appendix A of this SPD contains the Description of Plan Benefits. There is a separate Appendix A for each Plan described in this SPD: one for each of the Self-Funded HMO Plans. You should pay special attention to the Appendix A of this SPD that is applicable to the Plan in which you are enrolled. Appendix A describes:

- Benefits covered and the coverage levels
- Coverage exclusions
- Terms and conditions for benefits coverage
- Co-pays, deductibles, out-of-pocket maximums and coverage limitations
- Procedures for filing Claims for Plan Benefits
- Pre-certification and pre-authorization requirements, if any
- In-network and out-of-network provisions, if any
- Coordination of benefits ("COB") rules

Employee Assistance Plan

If you are an Employee enrolled in any of the Plans, you are eligible for free Employee Assistance Plan ("EAP") services. Retirees (and other Participants in The Dow Chemical Company Retiree Medical Care Program) are not eligible for the EAP.

The EAP provides professional and confidential counseling on emotional, social and mental health issues for employees and dependents experiencing personal difficulties. Participation is voluntary and typically self-referred. EAP support is available 24-hours per day, 7-days per week. The EAP provides up to six visits to an EAP counselor for assessment and referral or short-term counseling. The types of issues supported by the EAP include:

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

When EAP services are not medical in nature, they are called "EAP Direct Services." The part of the EAP that provides EAP Direct Services is not part of any Plan.[1] Sometimes, during EAP counseling sessions, a limited amount of mental health counseling occurs, which is medical in nature. The part of the EAP that provides these limited mental health services is a component of each of the Plans called "Medical EAP."

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

The EAP is administered by Aetna:

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

You may contact a local EAP provider at

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

While Medical EAP provides limited mental health benefits at no cost to you, if you are enrolled in a Plan, the Plan also provides more extensive mental health coverage; that coverage and the costs of coverage are described in the applicable Appendix A of this SPD.

Am I Still Eligible for the EAP If I Am Not Enrolled In a Self-Funded HMO Plan?

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

- You are enrolled in another Dow employee medical plan, Medical EAP benefits are provided by the plan in which you are enrolled.
- You are not enrolled in any Dow employee medical plan, Medical EAP benefits are provided under the MAP Plus Option 1 Low Deductible Plan offered under The Dow Chemical Company Medical Care Program.

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

If you die on or after May 7, 2015, while you are eligible for EAP services, your surviving Spouse/Domestic Partner and Dependent Child(ren) will be eligible for EAP services for up to one year after the date of your death.

Section 3. Eligibility

3.1 Self-Funded HMO Plan Availability

Besides meeting the eligibility requirements of this section, you must reside in the geographic locations where a Self-Funded HMO Plan is available:

- Blue Care Network is available in Michigan.
- Blue Cross/Blue Shield of Michigan (Illinois) is available in Illinois.
- CIGNA is available in Ohio, Texas, Illinois, New Jersey, North Carolina, or South Carolina.
- HealthPartners Minnesota is available in Minnesota.
- Humana is available in Louisiana.

If you move and thereby cease to be eligible for your Self-Funded HMO Plan, you may change your enrollment. See *Section 4.5 If You Move Out of HMO Covered Location During the Plan Year*.

3.2 Eligibility for Employees

As explained in this section of the SPD, The Dow Chemical Company Medical Care Program provides coverage for certain Employees.

Employees

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

- Are a Salaried U.S. Employee of a Participating Employer with active, Regular, Full-Time or Less-Than-Full-Time status, or are receiving partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008);
- Are an active, Regular, Full-Time Bargained-for U.S. Employee of a Participating Employer whose Bargaining Unit and Participating Employer have agreed to the Program. However, if the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Program, then the terms of such collective bargaining agreement shall govern; or
- Are an Employee who is retained by a Participating Employer pursuant to a written contract or agreement that states that you are eligible to participate in one of the Plans.

If you are receiving partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008), you are eligible as an Employee. You must continue making any required contributions in order to keep your coverage in effect. If your paycheck is not large enough to cover your entire premium, your Participating Employer will bill you directly.

Benefit Protected Leave of Absence

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

Severance Agreement

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

3.3 Eligibility for Retirees, DCC Retirees, and Certain Former Employees

As explained in this section of the SPD, The Dow Chemical Company Retiree Medical Care Program provides coverage for certain Retirees, DCC Retirees, disabled individuals, and other former Employees.

Retirees

The Dow Chemical Company Retiree Medical Care Program is applicable to eligible Retirees. "Retiree" is defined in the Plan Document and summarized in *Section 30. Definitions of Terms.*

The Program and the Plans described in this SPD are *not* applicable to you if:

- *You retired under the terms of the Union Carbide Employees' Pension Plan*. Instead, refer to the summary plan description for the Union Carbide Retiree Medical Care Program.
- *You retired under the terms of the Rohm and Haas Company Retirement Plan or the Morton International, Inc. Pension Plan for Collectively Bargained For Employees*. Instead, refer to the summary plan description for the Rohm and Haas Retiree Medical Care Program, which is part of

the Rohm and Haas Group Health Plan under the Rohm and Haas Company Health and Welfare Plan.

If you are a Retiree, you are eligible for coverage under the Program if you meet ***all*** of the following requirements:

- You are age 50 or older and have 10 or more years of Service (as defined in the Plan Document and summarized in *Section 30. Definitions of Terms*);
- You were Hired[2] by a Dow Entity before January 1, 2008;
- Your employer was a Dow Entity before January 1, 2008, and continues to be a Dow Entity at the time you Retire;
- You were eligible as an Employee for coverage under The Dow Chemical Company Medical Care Program immediately before your Retirement;
- 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 Dow Chemical Company Retirement Health Care Assistance Plan; the plans offered under The Dow Chemical Company Insured Health Program excluding the International Medical and Dental Plan; and, for former employees of Americas Styrenics LLC, the Americas Styrenics LLC Retiree Reimbursement Account Plan, but only if you never elect to participate in that plan after terminating employment with Americas Styrenics LLC);
- You are not precluded from eligibility under a provision in the Plan Document; and
- If you were a Bargained-for Employee, coverage has been extended to your bargaining unit.

If you were Hired by a Dow Entity on or after January 1, 1993, and you are Eligible for Medicare, you are NOT eligible for coverage under the Program. See *Eligibility If You or Your Dependents Are Eligible for Medicare*.

DCC Retirees

If you are a DCC Retiree as defined in the Plan Document and summarized in *Section 30. Definitions of Terms*, you are eligible for coverage under the Program as described in *Appendix F, Section F-1.1 Eligibility for DCC Retirees*.

Certain Disabled Individuals

Certain disabled individuals are eligible for coverage under The Dow Chemical Company Retiree Medical Care 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 all Participants whose eligibility is described in this Section 3.3 of the SPD.

Long Term Disability Participants (other than DCC Employees)

If you (i) were not a DCC Employee, (ii) are eligible to participate in the Dow Employees' Pension Plan, and (iii) have been approved to receive benefit payments from The Dow Chemical Company Long Term

[2] Please refer to the definition of "Hire" in *Section 30. Definitions of Terms* to determine whether you were Hired *by a Dow Entity* before January 1, 2008.

Disability Program ("LTD"), you are eligible for coverage under the Program under the following circumstances:

- <u>If your date of "full disability" (as defined under LTD) is on or after January 1, 2006, your eligibility begins when your LTD benefit payments begin. The following applies to you</u>:

  If you were Hired by Dow or Union Carbide on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), 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 prior to 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.

  If you were Hired by Dow or Union Carbide prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), and you have ten (10) or more years of Service, you are eligible for medical coverage until you are no longer eligible to receive payments from LTD.

  You will be required to pay the same premiums Employees pay.

- <u>If your date of "full disability" (as defined under LTD) is prior to January 1, 2006, the following applies to you:</u>

  You are eligible for medical coverage until you are no longer eligible to receive payments from LTD. Currently, Dow pays the full cost of coverage. Your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level you had when you were an Employee.

You are <u>*not*</u> eligible for the coverage under the Program or under The Dow Chemical Company Insured Health Program if you receive benefit payments from the LTD and you are a vested participant of the Union Carbide Corporation Employees' Pension Plan or the Rohm and Haas Company Retirement Plan. Instead, refer to the summary plan descriptions for the Union Carbide Corporation Retiree Medical Care Program or Union Carbide Corporation Insured Health Program, or the Rohm and Haas Company Health and Welfare Plan, whichever is applicable.

<u>*Disability Retirees under Dow Employees' Pension Plan*</u>

If you have been approved for disability retirement benefits under the DEPP component of the Dow Employees' Pension Plan, you may also be eligible for coverage under the Program. Eligibility under this provision ends if you no longer have "disability retiree" status under the DEPP component of the Dow Employees' Pension Plan. Currently, if the effective date of your disability retirement under the DEPP component of the Dow Employees' Pension Plan is before January 1, 2006, Dow pays the full premium. Your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level that you had when you were an Employee. Effective January 1, 2006, if the effective date of your disability retirement status under the DEPP component of the Dow Employees' Pension Plan is on or after January 1, 2006, Dow provides you a premium subsidy at the Full Service level, regardless of your actual years of service. You are required to pay a premium based on the Retiree Medical Support Schedule and the Retiree Medical Budget. See *Section 8. Retirees: Premiums and Premium Cap*.

<u>*Hampshire Long Term Disability Participants*</u>

If you were approved to receive a benefit payment from UNUM Life Insurance Company of America before December 8, 1998, under a long term disability benefit plan under a Hampshire Chemical Corporation Health and Welfare Plan, you are eligible for coverage under the Program for as long as you continue to be approved by UNUM to receive benefit payments from that long term disability plan. Dow pays the full premium for your coverage. Eligibility for medical coverage ends when UNUM determines that you are no longer eligible for disability payments under the Hampshire long term disability plan.

Michigan Operations Contract Disability

If you have been approved for disability benefits under the Michigan Operations Contract Disability Plan, you are eligible for coverage under the Program. Your medical plan and coverage level is the Plan and coverage level most comparable to the last plan and coverage level you had when you were an Employee. Your premium is the same as the premium active employees are required to pay for the comparable active employee plan. Your Dow plan will pay primary over Medicare.

Texas Total and Permanent Disability

If you have been approved for disability benefits under the Texas Hourly Total and Permanent Disability Plan, you are eligible for coverage under the Program. If you are eligible for coverage under the Program under this rule, Dow pays the full cost of coverage. Your medical plan and coverage level is the Plan and coverage level most comparable to the last plan and coverage level you had when you were an Employee.

DCC Long Term Disability Participants

If you were a DCC Employee, you are eligible for coverage under the Program as provided in *Appendix F, Section F-2.1. Eligible for Long Term Disability*.

Certain Other Disabled Participants

If you were an Employee who became disabled and was approved to receive a benefit under The Dow Chemical Company Contract Disability Plan or the Dow AgroSciences Long Term Disability Plan, you might also be eligible for coverage under the Program if you are eligible to participate in the Dow Employees' Pension Plan. Contact the Retiree Service Center for more information.

Certain Other Former Employees

Eligibility Because of 1993 Special Separation Payment Plan

If you began to receive a benefit under the Dow Employees Retirement Plan ("ERP") after you reached age 50, and you received a benefit under the 1993 Special Separation Payment Plan, you are eligible for coverage under The Dow Chemical Company Retiree Medical Care Program.

60 Point or 65 Point Retiree Medical Severance Plan Participants

If you meet the definition of "60 Point Retiree Medical Severance Plan Participant" or "65 Point Retiree Medical Severance Plan Participant" in the Plan Document, you are eligible to participate in The Dow Chemical Company Retiree Medical Care Program, but only if you are a vested participant of the Dow Employees' Pension Plan with a benefit under the DEPP component. If you are a 60 Point or 65 Point Retiree Medical Severance Plan Participant, your participation in the Program is subject to the same terms and conditions, and rights and privileges as a Retiree.

Mergers, Acquisitions and Other Special Situations

Special eligibility rules might apply if you were a part of a merger or acquisition, or a joint venture or other special business arrangement or situation. These special rules are provided in Article III of the Plan Document, and business units that are subject to these special rules are listed in *APPENDIX D Mergers, Acquisitions and Other Special Situations*. Contact the Retiree Service Center for more information.

Formerly Eligible for The International Medical and Dental Plan

Effective on and after January 1, 2018, you are eligible for coverage under the Program if you (1) are a citizen of the United States, (2) return from abroad to reside in the United States, (3) were eligible for medical coverage under The International Medical and Dental Plan of The Dow Chemical Company Insured Health Program (the "International Medical and Dental Plan") as a "retiree" (within the meaning of the International Medical and Dental Plan) immediately before your return to the United States, and (4) meet *all* of the following requirements:

- You are age 50 or older and have 10 or more years of Service (as defined in the Plan Document and summarized in *Section 30. Definitions of Terms*);
- You were Hired[3] by a Dow Entity before January 1, 2008;
- Your employer at retirement was a Dow Entity or a participating employer in the International Medical and Dental Plan, before January 1, 2008, and continues to be a Dow Entity or a participating employer in the International Medical and Dental Plan at the time you retire;
- You were eligible as an Employee for coverage under the International Medical and Dental Plan immediately before your retirement;
- 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 Dow Chemical Company Retirement Health Care Assistance Plan; the plans offered under The Dow Chemical Company Insured Health Program excluding the International Medical and Dental Plan; and, for former employees of Americas Styrenics LLC, the Americas Styrenics LLC Retiree Reimbursement Account Plan, but only if you never elect to participate in that plan after terminating employment with Americas Styrenics LLC);
- You are not precluded from eligibility under a provision in the Plan Document; and
- If you were a Bargained-for Employee, coverage has been extended to your bargaining unit.

If you were Hired by a Dow Entity (or an entity that was, on your date of hire, a member of the Company's controlled group of corporations, within the meaning of section 414(b) or section 414(c) of the Code) after December 31, 1992, and you are Eligible for Medicare, you are NOT eligible for coverage under either The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program. See *Eligibility If You or Your Dependents Are Eligible for Medicare*.

Eligibility If You or Your Dependents Are Eligible for Medicare

If you are a DCC Non-Grandfathered Retiree, special rules apply. See *Appendix F, Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare*.

If you are Eligible for Medicare, you are not eligible for coverage under a Self-Funded HMO Plan. You may still be eligible for other coverage under The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program if you meet the eligibility requirements of those programs. You should check the summary plan descriptions for those programs.

If you are Eligible for Medicare *and you are not eligible for coverage under The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program*, the following rules apply:

- Your Spouse of Record/Domestic Partner of Record may be able to continue coverage under a Self-Funded HMO Plan under the following circumstances:
    - Your Spouse of Record/Domestic Partner of Record is not Eligible for Medicare;
    - Your Spouse of Record/Domestic Partner of Record was covered under the Plan at the time your coverage under the Plan ended due to your Medicare-eligibility; and

[3] Please refer to the definition of "Hire" in *Section 30. Definitions of Terms* to determine whether you were Hired *by a Dow Entity* before January 1, 2008.

  - You pay a premium of 102% of the full, unsubsidized cost of coverage under the Plan based on your Spouse of Record's/Domestic Partner of Record's age.

- Once your Spouse of Record/Domestic Partner of Record is Eligible for Medicare, your Spouse of Record/Domestic Partner of Record loses coverage under the Plan.
- Dependent Child(ren) (if any) may continue coverage under a Self-Funded HMO Plan only so long as your Spouse of Record/Domestic Partner of Record remains eligible for and enrolled in a Self-Funded HMO Plan and continues to pay 102% of the full, unsubsidized cost of his or her own coverage. To continue coverage for Dependent Child(ren), your Spouse of Record/Domestic Partner of Record must pay a corresponding rate.

Retirees and those eligible for coverage under this Section 3.3 should refer to *Section 5.6 Medicare* for information on what you need to do when you become Medicare-eligible.

3.4 Dependent Eligibility

Eligible Employees, Retirees, and DCC Retirees (and other Participants eligible for coverage under Sections 3.2 or 3.3 of this SPD) can enroll their eligible Dependents. A Dependent may be either your Spouse/Domestic Partner (for Retirees or Participants eligible for coverage under Section 3.3 of this SPD, Spouse of Record/Domestic Partner of Record), or an eligible Dependent Child. You must be enrolled in the Plan in which you wish to enroll a Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) or Dependent Child. An exception applies if you are a Retiree who is Eligible for Medicare, as described immediately above. If you are a DCC Non-Grandfathered Retiree and you are no longer eligible to participate in the Plan because you are Eligible for Medicare and split coverage applies, you must be enrolled in The Dow Chemical Company Retiree Medical Care Program's Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees ("HRA Plan") to enroll your eligible Dependent(s) in this Plan (refer to the *Split Coverage* section under *DCC Non-Grandfathered Retirees* in *Appendix F, Section F-1.2*).

If you enroll your Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) or Dependent Child, you will be required to provide their Social Security numbers to the Plan.

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

Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record

For Retirees, your Spouse of Record/Domestic Partner of Record is generally your Spouse or Domestic Partner as of your Retirement. If you marry, remarry or enter into a new Domestic Partnership after Retirement (or after otherwise meeting the eligibility requirements under Section 3.2 of this SPD), your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow-sponsored retiree medical program.

However:

- if you Retired and remarried, or filed a Domestic Partner Statement satisfactory to the Plan Administrator, before December 31, 2002, you may continue to cover that Spouse of Record/Domestic Partner of Record so long as you remain Married or in the Domestic Partnership; and
- if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married.

Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement, and neither of the exceptions described in the two bullet points above apply, your new Spouse's or Domestic Partner's children (e.g., your step-children) who are not your birth or legally adopted children are not generally eligible for coverage under any Dow-sponsored retiree medical program.

Spouse of Record/Domestic Partner of Record also includes spouses/domestic partners of former DCC Employees who Retired on or before December 31, 2016, if such spouses/domestic partners were covered under the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees on December 31, 2016.

Spouse/Domestic Partner and Spouse of Record/Domestic Partner of Record Exclusions

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

- Eligible for subsidized coverage as a full-time employee or retiree under another employer's plan, but not enrolled for personal coverage in that plan or not enrolled in Medicare (if he or she is eligible for Medicare).[4] (See the *Working or Retired Spouse/Domestic Partner and Spouse of Record/Domestic Partner of Record Rule*, immediately below for details.);
- Enrolled for coverage as an Employee, Retiree, or DCC Retiree (or other former Employee) under another Dow or Dow-affiliated medical plan;
- An Employee and you are a Retiree. See *Section 4.4 Dual Dow, DCC, UCC, or ROH Coverage*; or
- Serving in the armed forces of any country.

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

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

Note: The rule described in this section regarding working or retired Spouses/Domestic Partners applies to all Participants. Accordingly, if you are a Retiree, references to your Spouse/Domestic Partner herein include your Spouse of Record/Domestic Partner of Record.

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

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

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

- If your Spouse/Domestic Partner has enrolled in coverage offered by his or her employer (or former employer), the payment of benefits under the Plan will be secondary to your Spouse's/Domestic Partner's coverage through his or her employer (or former employer) under the Plan's coordination of benefits rules.
- If your Spouse/Domestic Partner fails to enroll in appropriate coverage available through his or her own employer (or former employer):
  1. You will be charged 102% of the full cost of coverage (*i.e.*, without any employer subsidy, if applicable) retroactive to the first day that your Spouse/Domestic Partner was enrolled in the Plan and failed to enroll in his or her own employer's coverage.
  2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer), the Program may cancel coverage for you and/or your Spouse/Domestic Partner retroactive to the first day that your Spouse/Domestic Partner failed to enroll in the employer's coverage. If coverage is cancelled, you will be required to reimburse the Plan for claims paid during the coverage period. See *Section 26. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
  3. If you pay 102% of the full cost of coverage but you do not provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer by the date determined by the Plan Administrator, coverage will terminate as of the date that the Program learns that your Spouse/Domestic Partner failed to enroll in the employer coverage.
  4. If you pay 102% of the full cost of coverage and you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through his or her employer by the date determined by the Plan Administrator, your Spouse/Domestic Partner will remain covered under the Plan for the Plan Year.

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

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

Waiving Coverage – Working Spouse/Domestic Partner

You should consider carefully whether it is advantageous to enroll your Spouse/Domestic Partner (or for Retirees, Spouse of Record/Domestic Partner of Record) as a Dependent under the Program if the coverage offered by his or her employer is as comprehensive as or better than the Program's. Any Plan in which you enroll your Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) under the Program would be secondary to your Spouse's/Domestic Partner's (or 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/Domestic Partner and Spouse of Record/Domestic Partner of Record Rule*, above. You may choose to waive coverage for your Spouse/Domestic Partner (or 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's or Domestic Partner's natural or adopted child (or, for Retirees, must be your Spouse of Record's or Domestic Partner of Record's natural or adopted child); or
- a child for whom you or your Spouse/Domestic Partner (for Retirees, your Spouse of Record/Domestic Partner of Record) has 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) (except as provided below), 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.

If you had medical coverage under the medical component of the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees or the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees for your grandchild(ren) on December 31, 2016, Dependent Child includes such grandchild(ren) on file with Aetna. Any such grandchild(ren) ceases to be eligible on the earlier of (1) the day that your child, who is the parent of such grandchild(ren), ceases to meet the eligibility requirements that otherwise apply to Dependent Children (e.g., the end of the month in which your child turns age 26); (2) the day that the grandchild(ren) ceases to meet the eligibility requirements that otherwise apply to Dependent Children (e.g., the end of the month in which the grandchild turns age 26); or (3) the effective date on which you cancel coverage under the Program for the grandchild(ren). If you drop medical coverage under the Program for such grandchild(ren) at any time and for any reason, you may not again enroll such grandchild(ren) in the Program.

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

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

Dependent Child(ren) Exclusions

Your Dependent Child will *not* be eligible for coverage under the Program:

- *On or after age 26*. Coverage ends at the end of the month in which the child turns age 26. Children age 26 or older are not eligible, unless, prior to age 26, the child is incapable of self-sustaining employment because of a physical or mental disability and (1) is covered under the Plan on the last day of the month in which the child turns age 26; or (2) is not covered under the Plan, but, in addition to meeting the enrollment requirements described in *Section 4. Employee Enrollment* or *Section 5. Retiree Enrollment*, as applicable, you submit proof at the time of enrollment that the child was covered as a dependent under his or her parent's medical plan immediately prior to enrolling in the Plan. In either case, the disabled child must be principally dependent upon you for support. In addition to meeting any other requirements for proof of eligibility, you must submit proof of the child's initial and continuing dependency and disability. Proof of eligibility must be provided to the Plan (1) prior to age 26, if the child is covered under the Plan on the last day of the month in which the child turns age 26, or (2) at enrollment if you seek to enroll the child after reaching age 26. You must make any contribution required by the Plan to cover your child. Once coverage is terminated, it cannot be reinstated. Contact the HR Service Center or the Retiree Service Center for more information; or
- *If your Dependent Child is covered as a Dependent under another Dow-sponsored or UCC-sponsored medical plan*. All eligible children in a family must be covered by the same parent. (Exceptions may be made as necessary in stepchild situations.)

When your child is no longer eligible for Dependent coverage because of one of the above events, you may be eligible to make a new enrollment within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible (or, for a Dependent Child who loses coverage as a result of attaining age 26, at the end of the month in which the child turns age 26), 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 an Employee, Retiree, or DCC Retiree (or other individual eligible for coverage under Sections 3.2 or 3.3 of this SPD) has a "qualified medical child support order" for that child. A Qualified Medical Child Support Order ("QMCSO") is a court order that meets the Program's requirements to provide a child the right to be covered under one of the Plans offered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Program.

Typically, a divorce decree that orders the Employee, Retiree, or DCC Retiree (or other individual eligible for coverage under Sections 3.2 or 3.3 of this SPD) to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree (or a document signed by either the Employee, Retiree, DCC Retiree, or the custodial parent, provided with the divorce decree, and consistent with the divorce decree) contains the following information:

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

3.5 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 ("International Medical and Dental Plan") to determine their eligibility and coverage under that plan. Those who are eligible for coverage under the International Medical and Dental Plan are not eligible for coverage under any of the Self-Funded HMO Plans.

If you are no longer eligible for the International Medical and Dental Plan as a retiree because you are a citizen of the United States who has returned from abroad to reside in the United States, you may be eligible for coverage under the Program. See "*Formerly Eligible for The International Medical and Dental Plan*" above on page 12.

3.6 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 full discretion to interpret provisions of the SPD and the Plan Document and to make findings of fact. However, the Claims Administrator's determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants. If you would like the applicable Claims Administrator to determine whether you are eligible for coverage, you can file a Claim for an Eligibility Determination. See *Section 27. Claims Procedures*.

Section 4. Employee Enrollment

This section of the SPD describes the enrollment rules applicable to eligible Employees (as well as those Participants whose eligibility is described in Section 3.2 of this SPD).

4.1 Employees: Levels of Participation

The levels of participation available are:

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

You must be enrolled in this Plan in order to enroll your Dependent Spouse/Domestic Partner or Dependent Child in this Plan. You may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the HealthPartners Minnesota Self-Funded HMO Plan under the Program, your Dependent may not be enrolled in a different Self-Funded HMO Plan or in either of the MAP Plus Plans. Exceptions apply. See *Section 3.4 Dependent Eligibility*, above.

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

4.2 Enrolling at the Beginning of Employment

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

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

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

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

If you are enrolling your Spouse/Domestic Partner and/or Dependent Child(ren), you must provide proof of their eligibility within 90 days of your date of hire (the "90-Day Deadline"). 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 the 90-Day Deadline, you will receive a notification (**"Notification of Termination"**) that your Dependent's coverage terminated as of the 90th day after your date of hire. You may provide proof of Dependent eligibility by no later than 30 days after the date of the Notification of Termination (the **"30-Day Deadline"**) to have your Dependent reinstated retroactive to the first day that your Dependent was enrolled in the Plan without being charged 102% of the full cost of coverage.

If you do not submit proof of Dependent eligibility by the 30-Day Deadline, the following rules will apply:

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 through the date your Dependent's coverage was terminated (*i.e.*, the 90-Day Deadline) and you will be given a deadline by the Plan Administrator to pay this amount and to again provide acceptable proof of Dependent eligibility.
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 26. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, coverage will not be reinstated and will remain terminated as of the 90th day after your date of hire.

4. If you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent will be reinstated retroactive to the first day that your Dependent was enrolled in the Plan and 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*.

4.3 Enrolling During Annual Enrollment

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

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

If you wish to add a Dependent – either a Spouse/Domestic Partner or a child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. **You must provide proof of Dependent eligibility no later than 90 days after the start of the applicable Plan Year (the "90-Day Deadline").** 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 the 90-Day Deadline, you will receive a notification (**"Notification of Termination"**) that your Dependent's coverage terminated as of the 90th day after the start of the Plan Year. You may provide proof of Dependent eligibility by no later than 30 days after the date of the Notification of Termination (the **"30-Day Deadline"**) to have your Dependent reinstated retroactive to the beginning of the Plan Year without being charged 102% of the full cost of coverage.

If you do not submit proof of Dependent eligibility by the 30-Day Deadline, the following rules will apply:

1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan (*i.e.*, January 1st) through the date your Dependent's coverage was terminated (*i.e.*, the 90-Day Deadline) and you will be given a deadline by the Plan Administrator to pay this amount and to again provide acceptable proof of Dependent eligibility.

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 26. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.

3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will not be reinstated and will remain terminated as of the 90th day after the start of the Plan Year.

4. If you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent will be reinstated retroactive to January 1st and 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*.

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

4.4 Dual Dow, DCC, UCC, or ROH Coverage

If you and your Spouse/Domestic Partner are each independently eligible for coverage under a Dow-sponsored (which includes DCC and 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.)

4.5 If You Move Out of HMO Covered Location During the Plan Year

If you move during the Plan Year and remain eligible to participate in the Program, but your Self-Funded HMO 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 Human Resources Service Center within 90 days of your transfer (or 180 days for geographic location under the Participating Employer's relocation policy). Your ability to switch coverage is subject to the rules in *Section 6. Mid-Year Election Changes*.

4.6 Change of Elections to Prevent Discrimination

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

Section 5. Retiree Enrollment

This section of the SPD describes the enrollment rules applicable to Retirees (as well as those Participants eligible for coverage under Section 3.3 of this SPD). If you are Eligible for Medicare you may not enroll in any Self-Funded HMO Plan. See *Section 5.6 Medicare*, below.

5.1 Retirees: 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 a Plan in order to enroll your Spouse of Record/Domestic Partner of Record or Dependent Child in the Plan. In general, you may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in HealthPartners Minnesota Self-Funded HMO Plan, your Dependent may not be enrolled in a different Self-Funded HMO Plan or in either MAP Plus Plan. Exceptions apply. See *Section 3.4 Dependent Eligibility*, above.

5.2 Enrolling at Retirement

To enroll for Program coverage upon your Retirement, enroll on the Dow Benefits web site or by calling the Retiree Service Center. To avoid a gap in coverage, enroll within 31 days of Retirement. Your coverage will be effective as follows:

- If the Plan Administrator receives your enrollment request within 31 days after your Retirement, your enrollment will be effective as of your Retirement or, if later, your last day of coverage under a Dow active medical plan.
- If the Plan Administrator receives your enrollment request on day 32 through 90 after your Retirement, the effective date of your enrollment will be the Plan Administrator's processing date.

If you do not enroll yourself and/or your eligible Dependents within 90 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 6. Mid-Year Election Changes*).

Enrolling Your Spouse of Record/Domestic Partner of Record and Dependent Child(ren) at Time of Retirement—Proof of Eligibility

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 26. Payment of Unauthorized Benefits* for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of the date your proof of Dependent eligibility was required by the Plan Administrator.
4. If you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, 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*.

5.3 Retiree 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 5.4 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.

If you are Eligible for Medicare, you may not enroll in any Self-Funded HMO Plan. See *Section 5.6 Medicare*.

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

If you wish to add a Dependent, you must provide proof of Dependent eligibility no later than 90 days after the start of the applicable Plan Year (the **"90-Day Deadline"**). 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 the 90-Day Deadline, you will receive a notification (**"Notification of Termination"**) that your Dependent's coverage terminated as of the 90th day after the start of the Plan Year. You may provide proof of Dependent eligibility by no later than 30 days after the date of the Notification of Termination (the **"30-Day Deadline"**) to have your Dependent reinstated retroactive to the beginning of the Plan Year without being charged 102% of the full cost of coverage.

If you do not submit proof of Dependent eligibility by the 30-Day Deadline, the following rules will apply:

1. You will be charged 102% of the full cost of coverage (*i.e.,* without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan (*i.e.*, January 1st) through the date your Dependent's coverage was terminated (*i.e.*, the 90-Day

Deadline) and you will be given a deadline by the Plan Administrator to pay this amount and to again provide acceptable proof of Dependent eligibility.

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 26. Payment of Unauthorized Benefits* for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will not be reinstated and will remain terminated as of the 90th day after the start of the Plan Year.
4. If you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent will be reinstated retroactive to January 1st and 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*.

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/Domestic Partner and Spouse of Record/Domestic Partner of Record Rule*.

5.4 Re-Enrolling After Waiving Coverage

Waive Coverage Before Age 65

If at any time you waive coverage under the Program (*e.g.*, the MAP Plus Option 1 Low Deductible Plan, the MAP Plus Option 2 High Deductible Plan, and all other medical plans offered under the Program) before reaching age 65, and you subsequently would like to enroll for coverage under the Program, you may do so in accordance with the rules in *Section 5.3. Retiree Annual Enrollment* or *Section 6. Mid-Year Election Changes*, and your enrollment will be subject to the following rules:

- You may enroll in coverage under the Plan 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; 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; provided that you meet the eligibility requirements. However, you may not enroll in the MAP Plus Option 2 High Deductible Plan if you are eligible for Medicare for any reason.

Waive Coverage After Age 65

If at any time (on and after January 1, 2018 for DCC Non-Grandfathered Retirees), you waive coverage under the Program on or after reaching age 65, and you subsequently would like to enroll for coverage under the Program (other than a Self-Funded HMO Plan) or The Dow Chemical Company Insured Health Program, you may do so at the times and subject to the rules described in the applicable summary plan description. Please contact the Retiree Service Center for more information.

DCC Non-Grandfathered Retirees Enrolling After Age 65

If you are a DCC Non-Grandfathered Retiree and you are not eligible to participate in a medical plan offered under the Program because you are Eligible for Medicare and split coverage applies, you may enroll in the HRA Plan and purchase coverage on the Aon Retiree Health Exchange ("Exchange"), but only if—

- You submit proof at the time of enrollment that you lost active employee medical coverage sponsored by another employer, including an employer of your Spouse/Domestic Partner; or
- You submit proof at the time of enrollment that you lost subsidized retiree medical coverage sponsored by another former employer or a former employer of your Spouse/Domestic Partner because it was discontinued by the sponsoring employer.

If you satisfy the eligibility requirements, Dow may fund a health reimbursement arrangement ("HRA") under the HRA Plan that you can use towards the purchase of medical coverage on the Exchange. For more information about split coverage, the HRA Plan, and the Exchange, see the *DCC Non-Grandfathered Retirees* section in *Appendix F, Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare*.

5.5 Dual Dow, DCC, UCC, or ROH Coverage

If you and your Spouse of Record/Domestic Partner of Record are each independently eligible for coverage under a Dow-sponsored (which includes DCC and 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.)

5.6 Medicare

DCC Non-Grandfathered Retirees

If you are a DCC Non-Grandfathered Retiree, special rules apply. See *Appendix F, Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare*.

Age-Related Eligibility for Medicare

You are not eligible for coverage under a Plan if you are Eligible for Medicare. Accordingly, if you are enrolled in a Plan and you or your Spouse of Record/Domestic Partner of Record becomes Eligible for Medicare, your coverage under the Self-Funded HMO Plan will automatically end.

In general, your ability to switch to another plan or continue coverage in a Dow retiree medical plan depends on the date you were Hired. However, Retirees and other Participants from FilmTec Corporation are not eligible to participate in The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program once they become Eligible for Medicare, regardless of when they were hired; the rules applicable to such individuals are described in *If You Were Hired After December. 31, 1992 or were a FilmTec Employee*, below. Other special rules might apply if you have service with a company that was acquired by The Dow Chemical Company or with whom The Dow Chemical Company has entered into a joint venture or other business structure. Contact the Retiree Service Center for more information.

- **If You Were Hired Before January 1, 1993**

  If you are a Retiree who was Hired by the Company prior to January 1, 1993, and you lose coverage under a Plan as a result of Medicare eligibility, you may switch to another plan that permits Medicare-eligible Participants. No proof of insurability is required. You and your eligible Dependent must enroll in Medicare Parts A and B as soon as you are eligible. See the rules under *You Could Pay More If You Fail to Timely Enroll in Medicare*, below. Contact the Retiree Service Center for more information.

- **If You Were Hired After December 31, 1992 or Were a FilmTec Employee**

  If you were Hired after December 31, 1992, or you were a FilmTec employee, you are NOT eligible to participate in any medical plan offered under either The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program once you become Eligible for Medicare.

If you are not eligible to participate in a Dow retiree medical plan and you are eligible for Medicare, you should enroll in Medicare Parts A and B, or a Medicare Advantage HMO. However, you are not eligible to enroll in a Medicare Advantage HMO offered under The Dow Chemical Company Insured Health Program. You should also consider enrolling in Medicare Part D. ***Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.***

Non-Age Related Eligibility for Medicare

If you are eligible for Medicare because of a non-age related reason, such as because of a disability or end stage renal disease (ESRD), and you do not yet meet the Medicare age eligibility requirement (currently, age 65), you do not lose Dow retiree medical eligibility or coverage under this Plan until you meet the Medicare age eligibility requirements. However, you could pay more if you fail to timely enroll in Medicare. See below.

You Could Pay More If You Fail to Timely Enroll in Medicare

In general, if you are eligible for Medicare for any reason and do not enroll in Medicare Parts A and B, your coverage will be ***reduced*** by the amount that Medicare Parts A and B would have covered as if you had enrolled as of the date you were first eligible for Medicare.

For age related eligibility, Medicare rules may require you to enroll in Medicare Parts A and B ***during the three month period before you reach age 65***. ***Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.*** 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.

5.7 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 Self-Funded HMO 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 6. Mid-Year Election Changes*.

Section 6. Mid-Year Election Changes

If you are an **Employee**, in general, you purchase your Employee, Spouse, and Dependent Child coverage under the Program with premiums that are pre-tax dollars through the Dow Flexible Spending Plan, a plan intended to qualify under Section 125 of the Code as a "cafeteria plan." You may not enroll in the Plan outside of the enrollment periods described in *Section 4. Employee Enrollment* and pay premiums on a pre-tax basis, unless you meet the requirements of this Section 6. This Section 6 describes the rules for making a mid-year election change to enrollment in the Plan, including for special enrollment events or a "change in status," the exceptions to these rules, as well as the documentation required and deadlines for making a mid-year election change. Your ability to enroll yourself or your Dependent in a Plan pursuant to mid-year election change rules is subject to the eligibility rules for the Plan. See *Section 3. Eligibility*.

Regardless of whether you are a Retiree or an Employee you may generally change your enrollment in the Program or a Plan or change your level of participation (*e.g.*, Individual Only, Individual plus Spouse of Record/Domestic Partner of Record, Individual plus Child(ren), Individual plus Spouse of Record/Domestic Partner of Record plus Child(ren)) only as follows:

- During annual enrollment, you may make any change to your participation in the Program, including enrolling or disenrolling in the Program, changing to a different Plan, or changing your level of Participation by adding or dropping Dependents.
- If you have a special enrollment event described in *Section 6.1 Special Enrollment Provisions* or another permissible change event described in *Section 6.4 Other Permissible Changes*, you may enroll, increase your level of participation, or change to a different Plan outside of annual enrollment.
- If you have a "change in status", you will be permitted to change, outside of annual enrollment, your enrollment in the Program or a Plan or change your level of participation only to the extent that the change is consistent with the event. For example, you will be permitted to drop a Dependent following a change in status event only if the Dependent is no longer eligible for the Program as a result of the event.

If you are a **Retiree** (or other Participant eligible for coverage under Section 3.3 of this SPD), 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).

6.1 Special Enrollment Provisions

You may be eligible to enroll yourself and/or a Dependent 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/Domestic Partner or Spouse of Record/Domestic Partner of Record) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependent(s) outside of the usual annual enrollment period if you or your

Dependent loses 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 in the Plans 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***. Subject to the eligibility rules in *Section 3.4 Dependent Eligibility*, if you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may receive coverage under the Program for yourself and your new Dependent if you enroll in the Program within 90 days after the Marriage, Domestic Partnership, birth, adoption, or placement for adoption.
- ***Loss of Medicaid or SCHIP***. If you or your Dependent either (i) loses coverage under Medicaid or a State Child Health Insurance Plan ("SCHIP"), or (ii) becomes eligible for premium assistance under the Program through Medicaid or SCHIP, you may receive coverage for yourself and your Dependent if you enroll within 90 days.

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

6.2 Change in Status

For Employees (and other Participants Eligible Under Section 3.2 of this SPD)

For Employees, a "change in status" is an event listed in one of the bullets below:

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

For Retirees (and other Participants Eligible Under Section 3.3 of this SPD)

For Retirees (and other Participants eligible under Section 3.3 of this SPD) "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.

6.3 Consistency Rules

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

1. The change in status must ***result*** in you, your Spouse/Domestic Partner (or 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/Domestic Partner (or Spouse of Record/Domestic Partner of Record) or Dependent Child's employer.
2. The election change to the Dow-sponsored plan must ***correspond with*** that gain or loss of coverage.

The Program administers change in status events and the consistency rules the same way with respect to Domestic Partners/Domestic Partners of Record as Spouses/Spouses of Record, to the extent that such administration does not jeopardize the tax-qualified status of the Program.

6.4 Other Permissible Changes

You may change your enrollment in the Program or a Plan or your participation level mid-year without having met the change in status and consistency rule requirements only under the following circumstances and only to the extent permitted by the following rules:

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

Record's) employer's enrollment period is different from Dow's, your Spouse's/Domestic Partner's (or Spouse of Record's/Domestic Partner of Record's) election under his or her employer's plan may constitute a significant coverage change allowing you to change your Dow election. In each case, your new election must be on account of and correspond with the change under your Spouse's/Domestic Partner's (or Spouse of Record's/Domestic Partner of Record's) employer plan.

- ***Special Enrollment Rights –*** You may enroll yourself and/or a Dependent in a Plan mid-year if you meet, and to the extent permitted by, the special enrollment requirements addressed in *Section 6.1 Special Enrollment Provisions*.

6.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated changes you are permitted to make. Application of the rules above may differ for Retirees and former Employees. Any change is subject to meeting the Dependent eligibility rules and the eligibility rules for the relevant coverage option, as applicable. For Retirees, see also *Section 5.4 Re-Enrolling After Waiving Coverage*.

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll, you may increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse), or you may change to a different coverage option (*e.g.*, from a Self-Funded HMO Plan 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.*, Employee plus Spouse to Employee Only). You may not change to a different coverage option (*e.g.*, from a Self-Funded HMO Plan to MAP Plus Option 1 or MAP Plus Option 2) or cancel your participation.
Spouse/Domestic Partner loses medical coverage elsewhere	You may enroll, increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse), or change to a different coverage option (*e.g.*, from a Self-Funded HMO Plan to MAP Plus Option 1 or MAP Plus Option 2).
Move out of HMO service area	You may change to a different coverage option if you were enrolled in an HMO and move out of the HMO's service area. You may not change your level of participation (*e.g.*, Employee Only to Employee plus Spouse).
Move into an HMO service area	You may enroll in or change to an HMO for which you become eligible as a result of moving. You may not otherwise switch your coverage option (e.g., from one Self-Funded HMO Plan to another) or change your level of participation (*e.g.*, Employee Only to Employee plus Spouse).

6.6 Documentation of Eligibility Required to Make Election Changes

Documentation is required to show proof of eligibility to make a mid-year election change for yourself and/or a Dependent, and, if applicable, 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's/Domestic Partner's (or for Retirees, Spouse of Record's/Domestic Partner of Record's) or Dependent Child's employment, or any other form of proof the Plan Administrator deems appropriate. The Program reserves the right to, at any time, request proof of eligibility.

In general, you are required to provide proof of eligibility to make a mid-year election change for yourself and/or a Dependent, and, if applicable, proof of Dependent eligibility by day 90 after the change in status or special enrollment event (the **"90-Day Deadline"**). If you do not provide such proof by the 90-Day Deadline, you will receive a notification (**"Notification"**) that coverage for anyone enrolling mid-year (*i.e.*, you and/or your Dependent) terminated as of the 90-Day Deadline. You may provide proof by no later than 30 days after the Notification (the **"30-Day Deadline"**) to have you and/or your Dependent reinstated retroactive to the first day that you and/or your Dependent were enrolled in the Plan without being charged 102% of the full cost of coverage.

If you do not submit such proof by the 30-Day Deadline, the following rules will apply:

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 were enrolled in the Plan through the date you and/or your Dependent's coverage was terminated (*i.e.*, the 90-Day Deadline) and you will be given a deadline by the Plan Administrator to pay this amount and to again provide acceptable proof of Dependent eligibility.
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 eligibility to make a mid-year election change and/or 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 were 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 26. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of eligibility by the date determined by the Plan Administrator, coverage will not be reinstated and will terminate as of the 90th day after the change in status or special enrollment event.
4. If you pay 102% of the full cost of coverage and you provide acceptable proof of eligibility by the date determined by the Plan Administrator, you and/or your Dependent will be reinstated retroactive to the first day that you and/or your Dependent were enrolled in the Plan and 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 an Ineligible Dependent

If a Dependent becomes ineligible for the Program or a Plan, you are required to update your enrollment information on the Dow Benefits web site or notify the HR Service Center or the Retiree Service Center, as applicable, as explained in *Section 3.4 Dependent Eligibility*. If you fail to timely notify Dow that your Dependent is ineligible, you will continue to be obligated to pay premiums for the ineligible Dependent, coverage for the ineligible Dependent may be dropped retroactively (even if you paid premiums for the ineligible Dependent), and you may be required to reimburse the Plan for any medical benefits it already paid on behalf of the ineligible Dependent.

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

Dropping or Adding a Domestic Partner

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

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

6.7 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the fall of each year), you must submit the required proof of eligibility in accordance with *Section 6.6 Documentation of Eligibility Required to Make Election Changes* and request enrollment within 90 days of the change in status or special enrollment event (or within 180 days for geographic relocation under the Participating Employer's relocation policy) in order to avoid being charged 102% of the full cost of coverage.

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

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

Section 7. Employee Premiums

7.1 Your Contribution

You and Dow share the premium costs for your medical coverage. Your contributions to premiums are paid through payroll deductions. For your portion of the monthly premium, refer to the materials provided during the annual enrollment period.

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

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

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

7.2 Failure to Pay Required Premiums

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

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

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

In addition, the provisions of *Section 26. 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.

7.3 Excess Premium Payments

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

7.4 Premiums During a Benefits Protected Leave of Absence

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

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

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

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

Section 8. Retirees: Premiums and Premium Cap

You and Dow 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. Sections 8.1, 8.2, and 8.3 do not apply to DCC Retirees. If you are a DCC Retiree, see *Appendix F, Section F-1.3. DCC Retiree Premiums and Employer Subsidy*.

8.1 Retiree Medical Budget (Maximum Dow Subsidy, or the “Premium Cap”)

The Company has established a retiree medical budget. The Retiree Medical Budget is the maximum amount that the Company will pay toward medical premiums for the Program and for The Dow Chemical Company Insured Health Program (as applicable to Triple S and HMOs available to Retirees). ***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.***

The Retiree Medical Budget is determined by aggregating the Company’s contributions to retiree health care for all Retiree Medical Participants. The amount Dow contributes to the budget depends on:

- the number of Retiree Medical Participants eligible for Medicare;
- the number of Retiree Medical Participants not eligible for Medicare; and
- whether the Retiree Medical Participants have Full Service or have reduced support based on the Retiree Medical Support Schedule, as explained below in *Section 8.3 If You Retired After December 31, 1992*.

The Company’s total annual contribution to the Retiree Medical Budget shall not exceed a sum representing:

$6,800 for each Retiree Medical Participant with Full Service who is not eligible for Medicare;

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$2,000 for each Retiree Medical Participant with Full Service who is eligible for Medicare.

In addition, the Company contributes proportionally less for each Retiree Medical Participant with less than Full Service who is subject to the Retiree Medical Support Schedule. Once the Company has calculated the total budget for the upcoming year, the budget is allocated so that Full Service Retiree Medical Participants not eligible for Medicare and Full Service Retiree Medical Participants eligible for Medicare pay a similar percentage of the cost of their coverage as premiums. This allocation determines the maximum Company subsidy, or is the "cap" on the amount the Company will subsidize the premium for a Retiree Medical Participant with and without Medicare. Retiree Medical Participants are responsible for the portion of the total cost of retiree medical care coverage above the cap.

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.***

In general, all Participants and their Dependents are subject to the Retiree Medical Budget. (Certain exceptions apply for LTD Participants, DCC LTD Participants, and DCC Retirees and for special circumstances addressed in the Plan Document.) Surviving Spouses/Domestic Partners of Record of Employees (other than DCC Employees) pay "Full Service" retiree premiums after the Surviving Spouse of Record/Domestic Partner of Record reaches the age of 50.

8.2 If You Retired Before January 1, 1993

If you Retired before January 1, 1993, you are deemed to be a *Full Service* Retiree. Your contribution toward the total premium depends on (1) the medical coverage you elect and (2) whether you or your Spouse of Record/Domestic Partner of Record is eligible for Medicare. You will be charged the premium published for Full Service Retirees for the medical coverage that you elect.

8.3 If You Retired After December 31, 1992

If you Retired after December 31, 1992 (or you are a 60 Point or 65 Point Retiree Medical Severance Plan Participant whose employment terminated after December 31, 1992), you will receive the maximum Company support *only if* you have Full Service. The Company contribution toward the total premium will vary depending on (1) the medical coverage you elect, (2) your years of Service at the time you terminated employment, and (3) whether you are eligible for Medicare.

The Retiree Medical Support Schedule, on the next page, shows the additional premium you must contribute, which is calculated as a percentage of the Company's maximum subsidy. In general, your "Years of Service" is based on the definition of "Service" in the Plan Document and summarized in *Section 29. Definitions of Terms.* However, you are deemed to have 30 years of Service for purposes of the premium support schedule if you:

- Were Hired before January 1, 1993, by an employer who was a Participating Employer before January 1, 1993, and you retired on or after January 1, 1993, with 85 or more Points at your Retirement; or
- Were Hired by Union Carbide Corporation before February 6, 2001, and you have 85 or more Points at the time of your Retirement.

Special rules for determining your premium support might apply if you:

- Are a Retiree who met the definition of Transition Eligible Employee (as summarized in *Section 29. Definitions of Terms*) before your Retirement;
- Are a Retiree (or 60 Point or 65 Point Retiree Medical Severance Plan Participant) who was part of a merger or acquisition, or other special business arrangement listed in *Appendix D. Mergers, Acquisitions and Other Special Situations*; or
- Retired under The Dow Chemical Company 1993 Special Separation Payment Plan, The Dow Chemical Company Termination Payment Plan, The Dow Chemical Company Career Transition Assistance Plan, or another severance plan adopted by a Participating Employer.

Contact the Retiree Service Center for more information.

Retiree Medical Support Schedule

Years of Service[5] when Dow employment ended	Your Additional Contribution for Coverage (Your Percentage of Full Service Subsidy)	Dow's Contribution for Coverage (Dow's Percentage of Full Service Subsidy)
10	60%	40%
11	57%	43%
12	54%	46%
13	51%	49%
14	48%	52%
15	45%	55%
16	42%	58%
17	39%	61%
18	36%	64%
19	33%	67%
20	30%	70%
21	27%	73&
22	24%	76%
23	21%	79%
24	18%	82%
25	15%	85%
26	13%	87%
27	11%	89%
28	9%	91%
29	7%	93%
30 or more	0%**	100%**

**Note: In years before the Retiree Medical Budget is exceeded, the premium is set so that Full Service Retirees not eligible for Medicare pay an amount similar to the active employee contribution.

If you were hired before January 1, 1993, except as otherwise provided in the Plan Document, Dow will recognize your Eligibility Service at a Dow affiliate for purposes of the Retiree Medical Support Schedule if (and only if):

1. The affiliate was 50% or more owned by Dow on the date you were hired by it;
2. The affiliate either (A) provides a retiree medical plan to its employees that is comparable to the Program (including the employer subsidy) or (B) is located in a country (not the United States of America) whose government provides all, or substantially all, of the affiliate's retiree medical coverage comparable to the Program;
3. You are not a Retiree (or 60 Point or 65 Point Retiree Medical Severance Plan Participant) of FilmTec Corporation; and
4. Such eligibility service was not with FilmTec Corporation prior to January 1, 2000 or any other subsidiary or affiliate of the Company described in the Plan Document for which service is not recognized by the Program. Contact the Retiree Service Center for more details.

[5] See definition of "Service" in *Section 30. Definitions of Terms*.

8.4 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. In general, this means that if you do not enroll in Medicare, your coverage will be ***reduced*** by the amount that Medicare Parts A and B would have covered as if you had enrolled as of the date you were first eligible for Medicare.

For age-related eligibility, Medicare rules may require you to enroll in Medicare Parts A and B ***during the three month period before you reach age 65***.

However, if Dow provides the primary coverage instead of Medicare, you will be required to pay the premiums applicable to Retirees not eligible for Medicare. This could apply if, for example, you reside outside the U.S., you have been approved for disability benefits under the Michigan Operations Contract Disability Plan, or during the 30-month coordination period if you are eligible for Medicare due to end stage renal disease ("ESRD"), in which case you pay the applicable rates for Retirees not eligible for Medicare.

8.5 Premium Payments/Excess Premium Payments

If your monthly premium amount is less than your monthly Dow Employees' Pension Plan 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 26. 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 Deceased Employees (other than DCC Employees)

General Rule

In general, a Surviving Spouse/Domestic Partner of an 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, or see *Section 12.2 COBRA Continuation Coverage*.

If you are a Surviving Spouse/Domestic Partner of a DCC Employee, this Section 9.1 does not apply to you. Instead, see *Appendix F, Section F-1.4 Survivor Benefits*.

Exception for Active Employees Hired Before January 1, 2008

If the deceased Employee was hired before January 1, 2008 and was a vested participant of the Dow Employee's Pension Plan with a benefit under the DEPP component, an exception to the general rule above provides that a Surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program such as The Dow Chemical Company Retiree Medical Care Program. In such a case, the Surviving Spouse/Domestic Partner is eligible for coverage as a "Retiree" under The Dow Chemical Company Retiree Medical Care Program, in accordance with the following rules:

- If the deceased Employee would have been eligible for pre-Medicare retiree medical benefits had he or she continued to be employed at a Dow Entity and then Retired, then the Survivor is eligible for pre-Medicare benefits.
- If the deceased Employee would have been eligible for post-Medicare retiree medical benefits, then the Surviving Spouse/Domestic Partner is eligible for post-Medicare benefits. (Note that the Self-Funded HMO Plans offered under the Program are not available to any individuals who are Eligible for Medicare.)
- If the deceased Employee would not have been eligible for post-Medicare retiree medical benefits (*e.g.*, because the Employee was hired on or after January 1, 1993), then the Surviving Spouse/Domestic Partner is not eligible for post-Medicare benefits. In this case, once the Survivor is Eligible for Medicare, he or she is no longer eligible for coverage under the Program.
- If the Surviving Spouse/Domestic Partner is less than age 50 at the time of the Employee's death, he or she will be offered benefits under the Program at active employee rates until he or she reaches age 50. At age 50, the Surviving Spouse/Domestic Partner is required to pay retiree rates as if he or she were a Retiree with Full Service. If the deceased Employee would not have been eligible for post-Medicare retiree medical benefits, then such rates will continue until the Survivor is Eligible for Medicare. Once the Survivor is Eligible for Medicare, he or she is no longer eligible for coverage under the Program.
- If the Surviving Spouse/Domestic Partner remarries, he or she cannot cover a new spouse or domestic partner.
- A Surviving Spouse/Domestic Partner does not need to be enrolled at the time of death to be eligible. However, depending on whether he or she is covered under another health plan, he or she may be restricted in which Dow Plan he or she may enroll. The rules described above in *Section 5.4 Re-Enrolling After Waiving Coverage* apply.
- A Surviving Spouse/Domestic Partner who is employed full-time (or retired) and is eligible for employer-sponsored health coverage must be enrolled in that coverage in order to continue Dow coverage. If a Surviving Spouse/Domestic Partner is enrolled for Dow coverage, any surviving Dependent Child(ren) also may be covered as long as they meet eligibility requirements. In order to be eligible for coverage, the surviving Dependent Child(ren) must be enrolled in any employer-sponsored coverage for which they are eligible. Such Dependent Child(ren) will be subject to the corresponding premium rate that is applicable to the Surviving Spouse/Domestic Partner.

Vested Participants in the Union Carbide Employees' Pension Plan

If you were hired before January 1, 2008, and were a vested participant of the Union Carbide Employees' Pension Plan with a benefit under the UCEPP component, refer to the applicable UCC retiree medical summary plan description for a similar rule.

Vested Participants of the Rohm and Haas Company Retirement Plan

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

9.2 Surviving Spouse of Record/Domestic Partner of Record of Deceased Retirees and Deceased 60 Point and 65 Point Retiree Medical Severance Plan Participants

If you are a Surviving Spouse of Record/Domestic Partner of Record of a deceased DCC Retiree, this Section 8.2 does not apply to you. Instead, see *Appendix F, Section F-1.4 Survivor Benefits*.

If the Deceased Retiree Was Hired Before January 1, 2008

If the deceased Retiree (or 60 Point or 65 Point Retiree Medical Severance Plan Participant) was hired before January 1, 2008, and was a vested participant of the Dow Employees' Pension Plan with a benefit under the DEPP component, his or her Surviving Spouse of Record/Domestic Partner of Record may continue medical coverage under The Dow Chemical Company Retiree Medical Care Program, regardless of whether he or she was enrolled in coverage in the Program at the time of the Retiree's death, subject to the following rules:

- If the deceased Retiree's hire date was before January 1, 1993, the Surviving Spouse of Record/Domestic Partner of Record is eligible for Dow medical coverage following the Retiree's death.
- If the deceased Retiree's hire date was on or after January 1, 1993, and the Surviving Spouse of Record/Domestic Partner of Record is Eligible for Medicare at the time of the Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record is ineligible for coverage under any Dow retiree medical program.
- If the deceased Retiree's hire date was on or after January 1, 1993, and the Surviving Spouse of Record/Domestic Partner of Record is not Eligible for Medicare at the time of the Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record is eligible for pre-Medicare coverage under The Dow Chemical Company Retiree Medical Care Program and for such coverage must pay:
    - the applicable Retiree premium (as determined subject to the Retiree Medical Support Schedule and Retiree Medical Budget) the Retiree would have paid, until the date the Retiree would have become Medicare-eligible.
    - 102% of the full cost of coverage from the date the deceased Retiree would have become Medicare-eligible until the date the Surviving Spouse of Record/Domestic Partner of Record becomes Medicare eligible.

  The Surviving Spouse of Record/Domestic Partner of Record is not eligible for coverage after he or she becomes Eligible for Medicare.

- Depending on whether the Surviving Spouse of Record/Domestic Partner of Record is covered under another health plan at the time of the Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be restricted in which Dow Plan he or she may enroll.
- If a Surviving Spouse of Record/Domestic Partner of Record is employed full-time or is retired and is eligible for employer-sponsored health coverage (including from a former employer), the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that coverage in order to obtain coverage under The Dow Chemical Company Retiree Medical Care Program.

If the Deceased Retiree Was Hired On or After January 1, 2008

If the deceased Retiree was hired on or after January 1, 2008, the Survivor is eligible only for COBRA coverage for 36 months at 102% of the full cost of coverage. See *Section 12.2 COBRA Continuation Coverage*.

9.3 Surviving Spouse of Record/Domestic Partner of Record of a Deceased Individual Receiving Certain Disability Benefits

If the deceased individual is a Participant in The Dow Chemical Company Retiree Medical Care Program who had a disability approved for receipt of benefits under the Texas Total and Permanent Disability Plan or Michigan Contract Disability Plan, the Surviving Spouse of Record/Domestic Partner of Record is not required to pay a premium for coverage under the Program.

If the deceased individual is a Participant in The Dow Chemical Company Retiree Medical Care Program as a result of being eligible to participate in the Dow Employees' Pension Plan and approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), Survivor benefits are determined as follows:

- If the deceased LTD Participant was hired on or after January 1, 2008 or had less than ten years of Service, and dies while still eligible for the 12- or 24-month period of medical coverage during which the LTD Participant pays Employee premiums, the Surviving Spouse of Record/Domestic Partner of Record may continue coverage at the 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, the Surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules.
- If the deceased LTD Participant was hired before January 1, 2008 and had ten (10) or more years of Service at the time LTD payments commenced, and dies while still eligible for medical coverage, the Surviving Spouse of Record/Domestic Partner of Record is eligible for coverage under the same rules that apply to active employee deaths.

If the deceased individual is a Participant in the Program as a disabled individual described in *Appendix F, Section F-2.1. Eligible for Long Term Disability*, Survivor benefits are provided as described in *Appendix F, Section F-2.2 Survivor Benefits*.

9.4 Remarriage of a Surviving Spouse of Record/Domestic Partner of Record

Effective September 14, 2000, remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record from eligibility for coverage.[6] A Surviving Spouse of Record/Domestic Partner of Record may not cover his or her new spouse or domestic partner under the Program. If the Surviving Spouse of Record/Domestic Partner of Record waived coverage at the time of the Employee's, Retiree's, or DCC Retiree's (or 60 Point or 65 Point Retiree Medical Severance

[6] Remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record of a DCC Retiree from eligibility for coverage.

Plan Participant's or LTD Participant's or DCC LTD Participant'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 5.4 Re-Enrolling After Waiving Coverage*.

9.5 Surviving Children

If a Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program, the surviving child(ren) of the Retiree (or other Participant eligible for coverage under Section 3.3 of this SPD), including a biological child *in utero*, may also be covered. They must meet the Dependent eligibility requirements. If a Surviving Spouse of Record/Domestic Partner of Record works full time or is retired, he or she must enroll the surviving child(ren) in employer-sponsored health coverage for which they are eligible (including from a former employer).

If there is no Surviving Spouse/Domestic Partner (or for Retirees, Surviving Spouse of Record/Domestic Partner of Record), surviving Dependent Child(ren) who were eligible for coverage at the time of your death will be able to receive continued coverage for up to 36 months. This coverage meets the requirements of, and runs concurrently with, the coverage required under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA"). Dow subsidizes the COBRA premiums for the first 12 months following the death: during those first 12 months, surviving Dependent Child(ren) pay the premiums applicable to the Employee, Retiree, 60 Point or 65 Point Retiree Medical Severance Plan Participant, or LTD Participant, as applicable. Thereafter, if they were covered for the first 12 months and paid the required premiums, they will be offered the remaining 24 months of coverage at COBRA rates – 102% of the full cost of coverage. *In order to be covered, the surviving Dependent Child(ren) must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

If the surviving Dependent Child is a Dependent Child of a deceased DCC Employee or a DCC Retiree, Survivor benefits are provided as described in *Appendix F, Section F-1.4 Survivor Benefits*. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.

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. With regard to Plan coverage provided under The Dow Chemical Company Retiree Medical Care Program, 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, 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 ("WHCRA") requires that Plans offered under The Dow Chemical Company Medical Care Program provide Participants 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, this paragraph provides notice of your rights under the law. If a Participant receives benefits covered under the Plan in connection with a mastectomy and elects breast reconstruction, the Plan will provide coverage for:

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

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

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).

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. See *Appendix B. Notice of Privacy Practices*.

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 Dependent(s), including all costs of collection such as attorneys' fees and court costs; and/or (3) prohibit you from enrolling in the Program. In addition, your employer may terminate your employment, and your employer, 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 a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 12. Ending Coverage

12.1 When Coverage Ends

Except as otherwise provided in this Section 12.1, a Participant's coverage ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Participant elects not to participate for the Plan Year
- The Participant's death

- Termination of the Plan or Program
- Failure to pay the required premiums
- Failure to reimburse the Program for claims paid by the Program that, under the terms of the Program, you or your Dependent is required to reimburse the Program
- Failure to comply with the terms and conditions of the Program or the Plans
- Providing false or misleading information to the Program or the Plans

When your Dependent is no longer eligible, or dies, update your enrollment information on the Dow Benefits web site or by contacting the HR or Retiree Service Centers 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 (*e.g.*, the end of the month in which the child turns age 26), whether or not a reduction in your monthly premium occurs.

If you cease to be eligible to participate in the Program due to a voluntary termination of employment and you are eligible for either The Dow Chemical Company Retiree Medical Care Program, the Union Carbide Corporation Retiree Medical Care Program, or the Rohm and Haas Retiree Medical Care Program, your coverage terminates on the last day of the month in which you terminate employment.

If you cease to be eligible to participate in the Program and elect COBRA continuation coverage, your coverage terminates at the times described in *How Is COBRA Coverage Provided?*, below.

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

- elects COBRA (see *Section 12.2 COBRA Continuation Coverage*);
- continues to participate in accordance with *Eligibility If You or Your Dependents Are Eligible for Medicare* under Section 3.3 because you lost coverage under the Plan on account of becoming Eligible for Medicare; 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, the Program provides Domestic Partners (or for Retirees, Domestic Partners of Record) the same protection it provides Spouses (or Spouses of Record) that are covered under COBRA, consistent with the Program's definition and rules concerning Domestic Partners, and to the extent that it does not jeopardize the tax qualified status of the Program.

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

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

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

COBRA continuation coverage for the Program is administered by Willis 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 (or for Retirees, 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 an Employee, you will become a qualified beneficiary if you lose your coverage under the Program because of either of the following qualifying events:

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of a Retiree, the Retiree is a qualified beneficiary with respect to the bankruptcy. The Retiree's Spouse of Record, Surviving Spouse of Record, and Dependent Child(ren) 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 the end of employment or reduction of hours of employment, death of the Employee or Retiree, commencement of a proceeding in bankruptcy, or the Retiree's enrollment in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of any of these events.

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 call the HR Service Center or the Retiree Service Center within 60 days of the Dependent losing eligibility for coverage.

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

How Is COBRA Coverage Provided?

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

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

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

(1) Medicare Extension for Spouse and Dependent Children

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

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

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

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

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

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

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

Continuation coverage terminates before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees 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% (or, in the case of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage.

First Payment of Continuation Coverage

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

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

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

Periodic Payments for Continuation Coverage

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

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

Grace Periods for Periodic Payments

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate Recipients under QMCSOs

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Keep the Program Informed of Address Changes

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

Section 13. Subrogation

As used in this Section 13, these terms have the following meaning:

- "Covered Person" means a Participant (including a Retiree or DCC Retiree), the parents and legal guardians of a Participant who is a minor, and the heirs, administrators, and executors of a Participant'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 12 are assigned to the Program without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Program an assignment and other instruments that may be used to facilitate securing the rights of the Program. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

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

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

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

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

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 collective bargaining agreements (if applicable), the Plan Document, and the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.
- Continue health care coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You 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 your Self-Funded HMO Plan. For the contact information for the Plan Administrator and for your Self-Funded HMO Plan, see *Section 1. ERISA Information*. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Section 15. Plan Administrator's Discretion

The Plan Administrators are the Global Benefits Director and the North America Health and Insurance Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 27. 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 or her best judgment and sole discretion, based on his or her understanding of Dow's intent in establishing the Plan and taking into account all evidence (written and oral) that he or she 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 Programs and any or all of the Plans (including amending the Plan Documents 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 Programs are set forth in the Plan Documents.

If the Company terminates a Plan, the assets of the Plan, if any, shall 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 27. 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 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 or her 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 your Dependent, to an individual who has become the legal guardian for you or your Dependent by operation of state law, or to another individual whom the Administrator determines is the appropriate person to receive such benefits on behalf of you or your Dependent.

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

Section 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 Employee, Retiree, DCC 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 Employee, Retiree, DCC Retiree, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his or her 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 to 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 Participating Employers share the premium costs with the Participants. Participant contributions are either made through payroll deduction, deducted from pension benefits or paid separately by the Participant.

With respect to Participants of Plans that are part of The Dow Chemical Company Retiree Medical Care Program, the Company's contribution to Program costs (except with respect to DCC Retirees) is limited to the contribution limits established in April 1994, and amended in July 2001, unless adjusted by the Company, as described in *Section 8.1 Retiree Medical Budget (Maximum Dow Subsidy, or the "Premium Cap")*.

Benefits are paid from the Company's general assets.

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

Section 25. Uncashed Checks

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

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

Section 26. Payment of Unauthorized Benefits

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

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

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

Section 27. Claims Procedures

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

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

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation. See your Description of Benefits in Appendix A for procedures governing Claims for Plan Benefits. See *Section 27.4 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

27.1 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.

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

The Programs have more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you appeal an initial determination, the appellate decision is made by the Appeals

Administrator. Each of the Claims Administrators is a named fiduciary of the 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 entity named in the Appendix A applicable to your Self-Funded HMO.
- *Claims for an Eligibility Determination*. The Initial Claims Reviewers are the Human Resources Operations Compensation and Benefits Manager and the North America Health and Insurance Subject Matter Expert. The Appeals Administrators are the North America Health and Insurance Plans Leader and the North America Health and Insurance Plan Manager.

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 27. 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.

27.3 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Participant. The Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program. As described in the Description of Benefits (Appendix A of this SPD), 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.

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

- documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility Determination must be sent to:

Human Resources Operations Compensation and Benefits Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, Michigan 48641
Attention: Initial Claims Reviewer for The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program, as applicable (Claim for an Eligibility Determination)

Initial Determination

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

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

Appealing the Initial Determination

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

- The name of the Employee or Retiree/DCC Retiree;
- The name of the Dependent, if the Dependent is the person who is appealing the Administrator's decision;
- The name of the Plan (The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program, as applicable);
- Reference to the initial determination; and
- An explanation of the reason why you are appealing the initial determination.

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

North America Health and Insurance Plan Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, Michigan 48641

Attention: Appeals Administrator for The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program, as applicable (Claim for an 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 28. 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 29. 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 30. Definitions of Terms

The following are some of the defined terms of the Self-Funded HMO Plans. Additional terms are defined in the Plan Document for the Program and the applicable Description of Plan Benefits (Appendix A of this SPD). A copy of the Plan Document is available upon request of the Plan Administrator at the contact information provided in *Section 1. ERISA Information*.

60 Point Retiree Medical Severance Plan Participant

A "60 Point Retiree Medical Severance Plan Participant," as defined in the Plan Document.

65 Point Retiree Medical Severance Plan Participant

A "65 Point Retiree Medical Severance Plan Participant," as defined in the Plan Document.

Active Employee Points

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

Appeals Administrator

The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is the applicable Self-Funded HMO Plan administrator listed in *Section 1. ERISA Information* (i.e., Blue Care Network, Blue Cross/Blue Shield of Michigan (Illinois), CIGNA, HealthPartners or Humana). The Appeals Administrators with respect to reviewing an adverse Claim for an Eligibility Determination are the North America Health and Insurance Plans Leader and the North America Health and Insurance Plan Manager.

Bargained-for Employee

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

Blue Care or Blue Care Network

Blue Care Network of Michigan. Contact information is listed in *Section 1. ERISA Information*.

Blue Cross or Blue Cross/Blue Shield

Blue Cross/Blue Shield of Michigan. Contact information is listed in *Section 1. ERISA Information*.

CIGNA or CG

CIGNA or Connecticut General Life Insurance Company. Contact information is listed in *Section 1. ERISA Information*.

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 27. Claims Procedures*.

Claim for an Eligibility Determination

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

Claim for Plan Benefits

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

Claims Administrator

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

COBRA

The federal law (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) that allows a Participant 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.

Credited Service
Credited service recognized under the Dow Employees' Pension Plan.

DCC
Dow Silicones Corporation (Dow Corning Corporation prior to January 31, 2018).

DCC Deferred Retiree
A DCC Employee who terminated employment between 2001 and 2004 under a separation agreement with DCC that provides medical benefits under the Dow Corning Retiree Flex Benefits Plan, and who satisfies the requirements for medical benefits as set forth in the separation agreement.

DCC Employee
An Employee who was hired by DCC before October 1, 2016. If an Employee is re-hired by DCC or a Dow Entity, the Employee's first hire-date with DCC will be recognized for purposes of determining whether the Employee was hired before October 1, 2016 as follows:

1. If the Employee's employment with DCC terminated prior to January 1, 2006 (referred to as the "pre-January 1, 2006 termination date"), and the Employee was subsequently re-hired by DCC before October 1, 2016, and participated in the pre-2006 formula of Appendix J of the Dow Employees' Pension Plan (formerly the Dow Corning Corporation Employees' Retirement Plan) and no other formula under the Dow Employees' Pension Plan after the Employee's re-hire date, the Employee's first hire-date will be recognized by the Program.
2. If, as of the Employee's pre-January 1, 2006 termination date, the Employee was eligible for coverage under the DCC medical plan for retirees in effect on the date of the Employee's pre-January 1, 2006 termination date, the Employee's first hire-date will be recognized by the Program.
3. If an Employee's date of re-hire with any Dow Entity is on or after October 1, 2016, and the Employee's first hire-date is not recognized under clauses (1) or (2) above, the Employee is not a DCC Employee.

DCC Grandfathered Retiree
A DCC Employee who Retired before January 1, 1995, and otherwise met the requirements for retiree medical coverage under the DCC health and welfare plan for retirees in effect on the date of Retirement.

DCC LTD Participant
A former DCC Employee who was disabled under the DCC LTD Plan on December 31, 2016.

DCC LTD Plan
The Dow Corning Long Term Disability Plan (DCC Plan No. 505), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

DCC Non-Grandfathered Retiree
A DCC Employee who either (A) (1) was hired by DCC before January 1, 2006, (2) is age 50 or older with 10 years of DCC Service on the day preceding Retirement, and (3) was eligible to participate in the DCC health and welfare plan for active employees, The Dow Chemical Company Medical Care Program, or The Dow Chemical Company Insured Health Program (except The Dow Chemical Company International Medical and Dental Plan) on the day preceding Retirement, or (B) is a DCC Deferred Retiree.

DCC Retiree
A DCC Grandfathered Retiree or a DCC Non-Grandfathered Retiree.

DCC Service

The sum of your (1) "Credited Service" as defined in section 5.1(f) of Appendix J of the Dow Employees' Pension Plan ("Appendix J"), excluding service with other employers described in section 5.1(f)(ii) of Appendix J, and (2) service with Site Services, Inc.

Dependent

An Employee's Spouse, Domestic Partner, Dependent Child(ren), or a child to whom a Qualified Medical Child Support Order applies; or a Retiree's, DCC Retiree's, LTD Participant's, DCC LTD Participant's, or 60 Point or 65 Point Retiree Medical Severance Plan 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's or Domestic Partner's natural or adopted child (or, for Retirees, must be your Spouse of Record's or Domestic Partner of Record's natural or adopted child); or
- A child for whom you or your Spouse/Domestic Partner (for Retirees, your Spouse of Record/Domestic Partner of Record) has 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) (except as provided below), 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 3.4 of this SPD.

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

If you had medical coverage under the medical component of the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees or the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees for your grandchild(ren) on December 31, 2016, Dependent Child includes such grandchild(ren) on file with Aetna. Any such grandchild(ren) ceases to be eligible on the earlier of (1) the day that your child, who is the parent of such grandchild(ren), ceases to meet the eligibility requirements that otherwise apply to dependent children (*e.g.*, the end of the month in which your child turns age 26); (2) the day that the grandchild(ren) ceases to meet the eligibility requirements that otherwise apply to dependent children (*e.g.*, the end of the month in which the grandchild turns age 26); or (3) the effective date on which you cancel coverage under the Program for the grandchild(ren). If you drop medical coverage under the Program for such grandchild(ren) at any time and for any reason, you may not again enroll such grandchild(ren) in the Program.

DEPP component

The DEPP component of the Dow Employees' Pension Plan.

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 3.3 of this SPD)--

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

- who became eligible for coverage under the Program on or after January 1, 2003: a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic

Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.)

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

Special rules apply for Dow AgroSciences LLC Participants who Retired prior to January 1, 2006. Refer to Appendix III, Section III.17(i) of the Plan Document for The Dow Chemical Company Retiree Medical Care Program or contact the Retiree Service Center for more information.

This term also includes domestic partners of former DCC Employees who Retired on or before December 31, 2016, if such domestic partners were covered under the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees on December 31, 2016.

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

The Dow Chemical Company Long Term Disability Program
The Dow Chemical Company Long Term Disability Program (both ERISA Plan #506 and ERISA Plan #606).

Dow Entity
A "participating employer" of either The Dow Chemical Company Retiree Medical Care Program, 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.

Eligibility Service
Eligibility service recognized under the Dow Employees' Pension Plan.

Employee
A person who:

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

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

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement between the Participating Employer and another business, such as a leasing organization;
2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;
3. an individual who is classified or treated as an independent contractor; or

4. a self-employed individual, as defined in Code § 401(c)(1)(A), which generally means an individual who has net earnings from self-employment in a trade or business in which the personal services of the individual are a material income-producing factor.

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

Full Service

You are deemed to have Full Service if you Retired before January 1, 1993, with 10 or more years of Service.

If you were hired before January 1, 1993, and Retired after January 1, 1993, you have Full Service if you have either a minimum of 85 Points or you have thirty (30) or more years of Service recognized under the Retiree Medical Support Schedule.

If you were hired on or after January 1, 1993, you have Full Service if you have thirty or more years of Service recognized under the Retiree Medical Support Schedule.

For 60 Point and 65 Point Retiree Medical Severance Plan Participants, "Full Service" means a former Employee who has 30 or more years of Service at the time his or her employment with a Participating Employer terminates.

Special rules might apply if you were part of a merger or acquisition, or other special business arrangement listed in *Appendix D. Mergers, Acquisitions and Other Special Situations*. Refer to the Plan Document or contact the Retiree Service Center for more information.

This term does not apply to DCC Retirees.

HealthPartners or HPAI

HealthPartners Administrators Inc. Contact information is listed in *Section 1. ERISA Information*.

Highly Compensated Employee

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

HIPAA

The Health Insurance Portability and Accountability Act.

Hire, Hired, or Hire Date

When the terms "hire," "hired," or "hire date" are used in the SPD to determine whether a person was hired on or after January 1, 1993, the date the Employee first became eligible for coverage under The Dow Chemical Company Medical Care Program will be used. Likewise, when the terms "hire," "hired," or "hire date" are used in the SPD to determine whether a person was hired by Union Carbide Corporation on or after February 6, 2001, the date the Employee first became eligible for coverage under The Dow Chemical Company Medical Care Program will be used.

When the terms "hire," "hired," or "hire date" are used in the SPD to determine whether you were hired before January 1, 2008, the date that you first became eligible for coverage under The Dow Chemical Company Medical Care Program as an Employee will be used. If your employment with a Participating Employer terminated prior to January 1, 2008 (referred to as your "pre-January 1, 2008 termination date"), and you are subsequently re-hired by a Dow Entity, your first Hire Date will be recognized only if you were either:

- eligible for coverage under the Program as of your pre-January 1, 2008 termination date because you were a Retiree, 60 Point Retiree Medical Severance Plan Participant or a 65 Point Retiree Medical Severance Plan Participant; or
- not eligible for coverage under the Program as of your pre-January 1, 2008 termination date, but your date of re-hire with a Dow Entity is before January 1, 2016, and you participate in the DEPP component of the Dow Employees' Pension Plan after your re-hire.

For purposes of whether a Hire Date is on or after January 1, 1993, or before January 1, 2008, the following additional rules apply:

- For an employee of an entity acquired by the Company, the Program deems the hire date to be the later of (1) the date the entity became a Participating Employer under the Program, or (2) the employee's hire date at such entity.
- For an employee of an entity acquired by the Company that does not become a Participating Employer under the Program, if the employee is subsequently hired by the Company, the hire date shall be the date the *Company* hired such employee.

For Retirees who have been Localized in the U.S., for purposes of determining whether a Hire Date was on or after January 1, 1993, the Program recognizes hire dates and periods of employment with subsidiaries and affiliates that provide subsidized retiree medical coverage for their employees in an amount comparable to the Company's subsidization of the Program, and with subsidiaries and affiliates that are located in countries whose governments provide coverage comparable to the Program's coverage to such subsidiaries and affiliates' retirees.

Special rules might apply for determining your Hire Date if you were part of a merger or acquisition, or other special business arrangement listed in *Appendix D. Mergers, Acquisitions and Other Special Situations*. Refer to the Plan Document or contact the Retiree Service Center for more information.

HMO
Health Maintenance Organization.

Humana
Humana Insurance Company. Contact information is listed in *Section 1. ERISA Information*.

HRA Plan
The Dow Chemical Company Retiree Medical Care Program's Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees.

Initial Claims Reviewer
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the applicable Self-Funded HMO Plan administrator listed in *Section 1. ERISA Information*. (*i.e.*, Blue Care, Blue Cross, CIGNA, HealthPartners or Humana). The Initial Claims Reviewers with respect to deciding a Claim for an Eligibility Determination are the Human Resources Operations Compensation and Benefits Manager and the North America Health and Insurance Subject Matter Expert.

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

Localized
A person is "Localized" when an individual has been determined by a Participating Employer to be permanently relocated to a particular country, and the individual has accepted such determination. For

example, an Employee who is a Malaysian national is "Localized" to the U.S. when a Participating Employer has determined that such Employee is permanently relocated to the U.S., and such Employee has accepted such determination.

LTD

The Dow Chemical Company Long Term Disability Program (both ERISA Plan #506 and 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 Program shall be determined in accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue Service and the Department of Labor. For periods before September 16, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Program then in effect. The Program does not recognize common law marriages except that:

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

Medicare

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

"Medicare-eligible" or "Eligible for Medicare"

A person who is eligible for Medicare because he or she 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 or she 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.

Participant

An Employee, Retiree, DCC Retiree, Survivor, 60 Point Retiree Medical Severance Plan Participant, 65 Point Retiree Medical Severance Plan Participant, LTD Participant, DCC LTD Participant, Dependent, or other individual who meets the eligibility criteria of the Program, elects to participate in the Program, and remains eligible for benefits under the Program.

Participating Employer

The Company or one of its subsidiaries or affiliates that has been authorized by the Company to participate in the Program. "Participating Employers" and "Dow" have the same meaning and are used interchangeably. The Participating Employers of The Dow Chemical Company Medical Care Program (applicable to active Employees) are not necessarily the same employers as the Participating Employers of The Dow Chemical Company Retiree Medical Care Program (generally, only applicable to Retirees). Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan

One of the Self-Funded HMO Plans that is a component of each of The Dow Chemical Company Medical Care Program and The Dow Chemical Company Retiree Medical Care Program.

Plan Administrator

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

Plan Document

The plan document for either The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program, as applicable. Both Programs comprise ERISA Plan #501, and each incorporates the other by reference. The summary plan descriptions for the plans offered under the Programs are integral parts of the Plan Documents.

Program

Either The Dow Chemical Company Medical Care Program or The Dow Chemical Company Retiree Medical Care Program, or both, as applicable.

QMCSO

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

Regular Employee

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

"Retire" or "Retirement"

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

Retiree

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

- The former Employee was age 50 or older and had at least 10 years of Service at the time his or her employment terminated with a Dow Entity, is a "retiree" under the terms of the Dow Employees' Pension Plan, and has a vested benefit under the DEPP component of the Dow Employees' Pension Plan; or
- The former Employee has been Localized in the U.S. and:
  a. is still a Localized U.S. Employee when his or her employment with a Dow Entity ends;
  b. is age 50 or older with 10 or more years of Service when his or her employment with a Dow Entity ends;
  c. either
     i. at the time he or she was Localized in the U.S., he or she was eligible to participate in the DEPP component, although he or she need not participate in or be vested in the Dow Employees' Pension Plan at the time his or her employment ends; or
     ii. his or her hire date at a Dow subsidiary was prior to January 1, 2008, he or she was Localized in the U.S. between January 1, 2008 and September 1, 2009, and he or she is a vested participant in the PPA component of the Dow Employees' Pension Plan;

  and

  d. at the time his or her employment with the Dow Entity ends, he or she is not immediately transferred to an 80% or more owned Dow subsidiary or affiliate.

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

Retiree Medical Budget

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

Retiree Medical Participant

This term is used in the context of explaining the Retiree Medical Budget in *Section 8. Retirees: Premiums and Premium Cap*. It means a Retiree, 60 Point or 65 Point Retiree Medical Severance Plan Participant, an LTD Participant, or a Survivor who is a participant in a plan (other than the International Medical and Dental Plan) offered under The Dow Chemical Company Insured Health Program or is a Participant in the Program.

Self-Funded HMO Plan

Self-Funded HMO Plans are plans that have the same or similar plan design as an HMO, but are funded from Dow's general assets. The HMO administers the Self-Funded HMO Plan under a contract with Dow. Self-Funded HMO Plans "look" and "feel" like HMOs in most respects, except that the medical expenses are paid from Dow's general assets instead of the HMO's. The Self-Funded HMO Plans described in this SPD are:

- Blue Care Michigan Self-Funded HMO
- Blue Cross/Blue Shield of Michigan (Illinois) Self-Funded HMO

- CIGNA Self-Funded HMO
- HealthPartners Self-Funded HMO
- Humana Self-Funded HMO

Service

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

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

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

For purposes of calculating "Service," the following rules apply:

- For an employee of an entity acquired by the Company, the Program deems the hire date to be the later of (1) the date the entity became a Participating Employer under the Program, or (2) the employee's hire date at such entity.
- For an employee of an entity acquired by the Company that does not become a Participating Employer under the Program, if the employee is subsequently hired by the Company, the hire date shall be the date the Company hired such employee.
- For a former Employee who is re-hired <u>before</u> January 1, 2016--
  - ➢ If the Employee participates in the DEPP component of the Dow Employees' Pension Plan on the date of re-hire, the Program recognizes the first hire-date to determine whether "Service" means "eligibility" or "credited" service recognized by the Dow Employees' Pension Plan and to determine how much Service will be recognized by the Program.
  - ➢ If on the date employment terminated with Dow, the Employee was eligible for coverage under the Program as a Retiree or a 60 or 65 Point Retiree Medical Severance Plan Participant, the Program recognizes the first hire-date to determine whether "eligibility" or "credited" service is applicable and to determine how much Service will be recognized by the Program.
- For a former Employee who is re-hired <u>on or after</u> January 1, 2016--
  - ➢ If the Employee is re-hired and on the date employment terminated with Dow, the Employee was eligible for coverage under the Program as a Retiree or a 60 or 65 Point Retiree Medical Severance Plan Participant, the Program recognizes the first hire-date to determine whether "Service" means "eligibility" or "credited" service recognized by the Dow Employees' Pension Plan.
  - ➢ No Service on or after January 1, 2016, will be recognized by the Program for Employees re-hired on or after January 1, 2016.

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

- Only for purposes of determining eligibility, "Service" means the period(s) of time that the Retiree worked for the Company or any affiliate or subsidiary owned 80% or more by the Company.

- For purposes of determining whether the hire date was on or after January 1, 1993, the Program recognizes hire dates and periods of employment with subsidiaries and affiliates that provide subsidized retiree medical coverage for their employees in an amount comparable to the Company's subsidization of the Program, and with subsidiaries and affiliates that are located in countries whose governments provide coverage comparable to the Program's coverage to such subsidiaries and affiliates' retirees.
- For purposes of the Retiree Support Schedule, "Service" includes the period(s) of time that the Retiree worked for a 50% or more owned subsidiary or affiliate of the Company only if, during such period(s), such subsidiary or affiliate subsidized retiree medical coverage for its employees in an amount comparable to the Company's subsidization of the Program; or, such subsidiary or affiliate was located in a country whose government provides coverage comparable to the Program's coverage to such subsidiary or affiliate's retirees .

Special provisions regarding the definition of "Service" may apply in certain merger, acquisition, joint ventures and other special circumstances. For details, particularly if you were part of a merger or acquisition, or other special business arrangement listed in *APPENDIX D Mergers, Acquisitions and Other Special Situations*, contact the Retiree Service Center or refer to the Plan Document.

Spouse
A person who is Married to an Employee, Retiree, DCC Retiree, LTD Participant, DCC LTD Participant, or 60 Point or 65 Point Retiree Medical Severance Plan Participant. See the definition of Marriage for further details. With regard to a Retiree (or other Participant eligible for coverage under Section 3.3 of this SPD), your Spouse must be your Spouse of Record in order to be eligible for coverage under the Program.

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

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

With regard to a Participant who dies while an 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.

Special rules apply for Dow AgroSciences LLC Participants who Retired prior to January 1, 2006. Refer to Appendix III, Section III.17(i) of the Plan Document or contact the Retiree Service Center for more information.

This term also includes spouses of former DCC Employees who Retired on or before December 31, 2016, if such spouses were covered under the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees on December 31, 2016.

Summary Plan Description ("SPD")
The summary plan description for the Plans, including its appendices. This SPD is an integral part of each of the Plan Documents for The Dow Chemical Company Medical Care Program and The Dow Chemical Company Retiree Medical Care Program.

Surviving Spouse/Domestic Partner

The widowed Spouse/Domestic Partner of an Employee who was eligible to participate in The Dow Chemical Company Medical Care Program at the time of death of the Employee or is otherwise eligible as provided in *Appendix F*.

Surviving Spouse of Record/Domestic Partner of Record

The widowed Dependent Spouse of Record/Domestic Partner of Record of a Retiree (or any other Participant eligible for coverage under Section 3.3 of this SPD) 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 (or other Participant) or is otherwise eligible as provided in *Appendix F*; provided, that (except with respect to DCC Retirees and DCC LTD Participants) the deceased was a vested participant of the Dow Employees' Pension 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.

Transition Eligible Employees

Employees (other than DCC Employees) hired prior to January 1, 1993, who:

a. Are age 47 or older as of January 1, 1993, not eligible to Retire under The Dow Chemical Company Employees' Retirement Plan as of January 1, 1993, and unable to obtain 85 points in terms of age and service before becoming Eligible for Medicare;

b. Are age 55 or older as of January 1, 1993, not eligible to obtain an unreduced benefit under The Dow Chemical Company Employees' Retirement Plan as of January 1, 1993, and unable to obtain 85 points in terms of age and service before becoming Eligible for Medicare; or

c. Are age 55 or older as of January 1, 1993, not eligible to Retire under The Dow Chemical Company Employees' Retirement Plan as of January 1, 1993, and unable to obtain 85 points in terms of age and service before becoming Eligible for Medicare.

A "Transition Eligible Employee" is not the same as a "Transition Eligible DAS Participant." See the Plan Document for the definition of a "Transition Eligible DAS Participant."

UCC or Union Carbide

Union Carbide Corporation and certain of its subsidiaries.

VPHR

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

Section 31. For More Information

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

IMPORTANT NOTE

This booklet is the Summary Plan Description ("SPD") for the Self-Funded HMO Plans offered under The Dow Chemical Company Medical Care Program and The Dow Chemical Company Retiree Medical Care Program, as applicable (the "Programs"). However, this SPD is not all-inclusive and it is not intended to take the place of the Programs' legal documents.

The Dow Chemical Company reserves the right to amend, modify or terminate the Programs (including any underlying Plans) 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 Programs 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 Programs had never existed.

APPENDIX A. Description of Plan Benefits

- Blue Cross Blue Shield of Illinois HMO Plan
- Blue Care Network HMO Plan
- CIGNA HMO Plan
- Health Partners HMO Plan
- Humana HMO Plan

APPENDIX B. Notice of Privacy Practices

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

Effective Date of Notice: January 1, 2017

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

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

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

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

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

B.1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

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

Treatment is the provision, coordination or management of health care and related services. It also includes, but is

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

not limited to, consultations and referrals between one or more of your providers. For example, The Dow Chemical Company Dental Assistance Program may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

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

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

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

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

Uses and Disclosures that Require Your Written Authorization

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

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

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

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

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

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

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

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

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

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

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

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

Prohibited Uses and Disclosures

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

B.2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

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

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

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Requests to restrict uses and disclosures of your PHI should be made to the following person: Privacy Official; The Dow Chemical Company

Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

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

Right to Inspect and Copy PHI

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

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

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

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

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

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

Right to Request Amendment of PHI

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

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

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

Right to Receive an Accounting of PHI Disclosures

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

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

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

You or your personal representative will be required to complete a form to request an accounting of PHI disclosures. Requests for an accounting of PHI disclosures should be made to the following person: Privacy Official; The Dow Chemical Company Health

Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

Right to Receive a Paper Copy of This Notice Upon Request

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

A Note About Personal Representatives

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

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

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

B.3. The Plan's Duties

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

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

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

Minimum Necessary Standard

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

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

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

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

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

Whom to Contact at the Plan for More Information

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

B.4. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance

Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* parts 160 and 164. This notice attempts to summarize the regulations and set forth the Plan's legal duties, privacy practices, policies and procedures regarding your PHI. The regulations will supersede any discrepancy between the information in this notice and the regulations.

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

Applicable to Plan Year 2017

The Dow Chemical Company Medical Care Program and Retiree Medical Care Program *do* provide *Creditable* Coverage for prescription drugs for the following plans:

- **Blue Care Network**
- **Blue Cross/Blue Shield of Michigan (Illinois)**
- **CIGNA**
- **HealthPartners Minnesota**
- **Humana**

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

APPENDIX D. Mergers, Acquisitions and Other Special Situations

If you are a former employee and were a part of one of the entities listed below, Article III, Section 3.1 of the Plan Document for The Dow Chemical Company Retiree Medical Care Program provides special rules regarding your eligibility under The Dow Chemical Company Retiree Medical Care Program. Contact the Retiree Service Center for more information, or you may request a copy of the Plan Document from the Plan Administrator at the contact information provided in *Section 1. ERISA Information*.

Agrigenetics, Inc. d/b/a Mycogen Seeds
Dow DuPont Elastomers
Hampshire Chemical Company
I.E. du Pont de Nemours and Company
Dow Corning Corporation
Solutia Inc.
ANGUS Chemical Company
Essex Specialty Products, Inc.
FilmTec Corporation
Flexible Products Company
General Latex
Cargill Dow
Collaborative BioAlliance
EDS
ELEMICA
Dow AgroScience LLC
Celotex
Union Carbide Corporation
Dow Reichhold Specialty Latex LLC
Reichhold Inc.
Johann Haltermann Ltd.
Diamond Technology Partnership Corporation
Mycogen
Buildscape LLC
Merrell Dow Pharmaceuticals Inc.
CD Medical, Inc.
Celanese AG
DowBrands, Inc.
MEGlobal Americas, Inc.
Wolff Cellulosics LLC (7/1/07 through 10/31/07)
Walsroder Packaging LLC (11/1/07 through 8/31/08)
Business Process Service Center ("BPSC")
Business Services LLC
SafeChem North America LLC
Olin Corporation
Dow Silicones Corporation (Dow Corning Corporation prior to January 31, 2018) (See Appendix F)

APPENDIX E. CHIP Premium Assistance Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178 Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, 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

OMB Control Number 1210-0137 (expires 12/31/2019)

APPENDIX F. Dow Corning Corporation

Section F-1. DCC Retirees

F-1.1 Eligibility for DCC Retirees

The Program is applicable to eligible DCC Retirees (as defined in the Plan Document and summarized in *Section 30. Definitions of Terms*). The Program is ***not*** applicable to you if you were hired by DCC on or after January 1, 2006, or if you are re-hired by DCC or Dow on or after October 1, 2016 (and were not eligible for retiree medical coverage at the time of your earlier termination). If you were re-hired by DCC before October 1, 2016, and your earlier hire date was before January 1, 2006, you could be eligible for coverage under the Program if you satisfy the eligibility rules below.

If you were a DCC Employee, you are eligible for coverage under the Program if:

- You are a DCC Grandfathered Retiree — a DCC Employee who Retired before January 1, 1995, and otherwise met the requirements for retiree medical coverage under the DCC health and welfare plan for retirees in effect on the date of Retirement.
- You are a DCC Non-Grandfathered Retiree—
  1. A DCC Employee who (1) was hired by DCC before January 1, 2006, (2) is age 50 or older with 10 years of DCC Service on the day preceding Retirement, and (3) was eligible to participate in the DCC health and welfare plan for active employees, The Dow Chemical Company Medical Care Program, or The Dow Chemical Company Insured Health Program (except The Dow Chemical Company International Medical and Dental Plan) on the day preceding Retirement; or
  2. A DCC Deferred Retiree — A DCC Employee who terminated employment between 2001 and 2004 under a separation agreement with DCC that provides medical benefits under the Dow Corning Retiree Flex Benefits Plan, and who satisfies the requirements for medical benefits as set forth in the separation agreement.

F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare

This Section F-1.2 applies to DCC Retirees.

DCC Grandfathered Retirees

If you are a DCC Grandfathered Retiree and you are or become Eligible for Medicare, you are not eligible for coverage under a Self-Funded HMO Plan. The rules described in the subheading *Eligibility If You or Your Dependents Are Eligible for Medicare* under Section 3.3 apply to you.

DCC Non-Grandfathered Retirees

If you are a DCC Non-Grandfathered Retiree, the following rules apply to you and your Dependents when you or your Dependents become Eligible for Medicare. If you are Eligible for Medicare, you should enroll in Medicare Parts A and B, or a Medicare Advantage Plan, and you should consider enrolling in Medicare Part D. (Note: You are ***not*** eligible to enroll in a Medicare Advantage Plan offered under The Dow Chemical Company Insured Health Program.) Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.

In general, you must be enrolled in a Plan in order to enroll a Spouse of Record/Domestic Partner of Record or Dependent Child in the Plan. If you are a DCC Non-Grandfathered Retiree and you are no longer eligible to participate in the Plan because you are Eligible for Medicare and split coverage (described below) applies, you must be enrolled in the HRA Plan to enroll your eligible Dependent(s) in this Plan. Prior to split coverage, if you or your eligible Dependent(s) are Eligible for Medicare, you and your enrolled Dependent(s) will no longer be covered by this Self-Funded HMO Plan; and you may enroll in another plan under The Dow Chemical Company Retiree Medical Care Program (but not the HRA Plan or this Self-Funded HMO Plan) or The Dow Chemical Company Insured Health Program if you are otherwise eligible.

Prior to Split Coverage

Before Dow transitions to split coverage (described below), if you or your enrolled Dependents are Eligible for Medicare, you and your enrolled Dependents may enroll in any other plan for which you are eligible under The Dow Chemical Company Retiree Medical Care Program (but not the HRA Plan or this Self-Funded HMO Plan) or The Dow Chemical Company Insured Health Program until you and all of your enrolled Dependents are Eligible for Medicare. After you and all of your enrolled Dependents become Eligible for Medicare, Dow may fund a health reimbursement arrangement ("HRA") under the HRA Plan that you can use towards the purchase of medical coverage on the Aon Retiree Health Exchange ("Exchange"), if you satisfy the eligibility requirements for an HRA under the HRA Plan. See the summary plan description for the HRA Plan for more information about eligibility for the HRA. Contact the Retiree Service Center for more information about the Exchange.

Split Coverage

When Dow transitions to split coverage (see below for effective dates), you and any enrolled Dependents will no longer be eligible for coverage under The Dow Chemical Company Retiree Medical Care Program (except the HRA Plan) or The Dow Chemical Company Insured Health Program as soon as you or an enrolled Dependent becomes Eligible for Medicare (subject to the extension for those who enroll at Retirement, described below). Instead, you and any enrolled Dependents who are Eligible for Medicare may be eligible for the HRA Plan and to purchase coverage on the Exchange (described above).

Dow will transition to split coverage as follows:

- If you or your Dependent either (a) first becomes Eligible for Medicare on or after April 1, 2017, or (b) enrolls in the Program on or after April 1, 2017, split coverage applies immediately.
- If you or your Dependent enrolls in the Program before April 1, 2017, and becomes Eligible for Medicare before April 1, 2017, split coverage applies effective January 1, 2018.

Extended Eligibility for Plan If You Enroll at Retirement

On or after April 1, 2017, if you first enroll in the Program at Retirement in accordance with *Section 5.2 Enrolling at Retirement*, you and your eligible Dependents will participate in a Self-Funded HMO Plan for up to two calendar months following the last day of the month in which you Retire (*i.e.*, the day you lose coverage under a Dow-sponsored medical plan for Employees), even if you or your Dependent(s) are eligible for Medicare at that time. At the end of the two-month period, you and any enrolled Dependents who are Eligible for Medicare will no longer be eligible for coverage under a Self-Funded HMO Plan and must have enrolled in the HRA Plan and the Exchange, if eligible. You and any enrolled Dependents who are not yet Eligible for Medicare will remain eligible for coverage under the Plan.

F-1.3 DCC Retiree Premiums and Employer Subsidy

If you are a DCC Retiree, you and your Employer share the premium costs for your medical coverage under the Program. This Section F-1.3 describes the subsidies DCC Retirees may be entitled to receive towards the cost of medical coverage under the Program. If you and/or your Dependents are eligible to participate in the HRA Plan and the Aon Retiree Health Exchange ("Exchange"), as described in *Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare* above, you may be eligible to receive a contribution to a health reimbursement arrangement ("HRA") under the HRA Plan that you can use towards the purchase of medical coverage on the Exchange. See the summary plan description for the HRA Plan for more information about eligibility for the HRA. For more information about the Exchange, contact the Retiree Service Center.

Subsidy for DCC Grandfathered Retirees

If you are a DCC Grandfathered Retiree who is eligible for medical coverage under the Program, and you signed a benefit agreement at the time of your Retirement, you will receive the subsidy set forth in your benefit agreement. If you did not sign a benefit agreement at the time of your Retirement, you will receive the annual, adjustable subsidy that Dow communicates to you on an annual basis.

Subsidy for DCC Non-Grandfathered Retirees (other than DCC Deferred Retirees)

If you are a Non-Grandfathered Retiree (and not a DCC Deferred Retiree or do not have a special agreement) who is eligible for medical coverage under the Program, the amount of your subsidy depends on your current age and your eligibility at Retirement to receive a Full Subsidy.

The following table indicates the amount of the Full Subsidy for each age group. If you are not eligible for a Full Subsidy (see below), your subsidy will be the Full Subsidy prorated as described below.

Your Age	Full Subsidy
You are under age 65	$6,000 for each covered individual, up to a family maximum of $18,000
You are age 65 or older	$3,000 for each covered individual, up to a family maximum of $9,000

Full Subsidy

You are eligible for a Full Subsidy if on the date you Retire:

- you are age 60 or older with 10 or more years of DCC Service,
- you have 30 or more years of DCC Service, or
- the sum of your age and DCC Service equals or exceeds 85.

Prorated Subsidy

If you are not eligible for a Full Subsidy, your subsidy will be the Full Subsidy multiplied by a "factor," the denominator of which is 30 and the numerator of which is your DCC Service on the date you Retire.

Subsidy for DCC Deferred Retirees and Others with Special Agreements

If you are a DCC Deferred Retiree, a DCC Non-Grandfathered Retiree with a special agreement (*e.g.*, executive agreement, severance agreement, or are eligible under the Program pursuant to the terms of an acquisition) who is eligible for medical coverage under the Program, your subsidy will be determined pursuant to your separation agreement, other special agreement, or the terms of the acquisition.

Premium Payments/Excess Premium Payments

If your monthly premium amount is less than your monthly Dow Employees' Pension Plan 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 26. 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.

F-1.4 Survivor Benefits

Surviving Dependent of a Deceased DCC Employee

If the deceased DCC Employee was hired by DCC before January 1, 2006, his or her Dependent is eligible for coverage as a "DCC Retiree" under the Program, in accordance with the following rules:

- If the deceased DCC Employee would have been a DCC Grandfathered Retiree on his or her date of death, a Surviving Spouse/Domestic Partner will be eligible for medical coverage under the Program as a DCC Grandfathered Retiree.
- If the deceased DCC Employee would have been a DCC Non-Grandfathered Retiree on his or her date of death, a Surviving Spouse/Domestic Partner will be eligible for medical coverage under the Program as a DCC Non-Grandfathered Retiree.
- If the Surviving Spouse/Domestic Partner remarries, he or she cannot cover a new spouse or domestic partner.
- A Surviving Spouse/Domestic Partner does not need to be enrolled at the time of death to be eligible. However, depending on whether he or she is covered under another health plan, he or she may be restricted in which Dow Plan he or she may enroll. The rules described in *Section 5.4 Re-Enrolling After Waiving Coverage* apply.
- A Surviving Spouse/Domestic Partner who is employed full-time (or retired) and is eligible for employer-sponsored health coverage must be enrolled in that coverage in order to continue Dow coverage. If a Surviving Spouse/Domestic Partner is enrolled for Dow coverage, any surviving Dependent Child(ren) also may be covered as long as they meet eligibility requirements described in *Section 9.5 Surviving Children*. In order to be eligible for coverage, the surviving Dependent Child(ren) must be enrolled in any employer-sponsored coverage for which they are eligible. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.
- If the Surviving Spouse/Domestic Partner is less than age 50 at the time of the active DCC Employee's death, he or she will be offered benefits under the Program at active employee rates until he or she reaches age 50.
- At age 50, the Surviving Spouse/Domestic Partner will receive the Full Subsidy described in *Section F-1.3 DCC Retiree Premiums and Employer Subsidy*, above.

- At age 65, if the Surviving Spouse/Domestic Partner becomes eligible to participate in the HRA Plan and the Aon Retiree Health Exchange ("Exchange"), as described in *Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare* above, the Surviving Spouse/Domestic Partner may be eligible to receive a contribution to a health reimbursement arrangement ("HRA") under the HRA Plan that may be used towards the purchase of medical coverage on the Exchange. See the summary plan description for the HRA Plan for more information about eligibility for the HRA. For more information about the Exchange, contact the Retiree Service Center.

Surviving Dependent of a Deceased DCC Retiree

If you are a surviving Dependent of a DCC Retiree who was hired on or after January 1, 2006, you are not eligible for medical coverage under this Program.

DCC Grandfathered Retiree

If you are a Surviving Spouse of Record/Domestic Partner of Record of a DCC Grandfathered Retiree, you are eligible for medical coverage under the Program as a DCC Grandfathered Retiree. If you are a surviving Dependent Child of a DCC Grandfathered Retiree, you are eligible for medical coverage under the Program as a Dependent Child of a DCC Grandfathered Retiree until you cease to be a Dependent Child (generally, until you turn age 26); provided the Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program and you meet the eligibility requirements described in *Section 9.5 Surviving Children*. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.

Depending on whether the Surviving Spouse of Record/Domestic Partner of Record is covered under another health plan at the time of the Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be restricted in which Dow Plan he or she may enroll.

If a Surviving Spouse of Record/Domestic Partner of Record is employed full-time or is retired, and is eligible for employer-sponsored health coverage (including from a former employer), the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that coverage in order to obtain coverage under the Program.

If the deceased DCC Grandfathered Retiree signed a benefit agreement at the time of his or her Retirement, the surviving Dependent will receive the subsidy set forth in the benefit agreement. If he or she did not sign a benefit agreement, the amount of any subsidy will be communicated by Dow on an annual basis.

DCC Non-Grandfathered Retiree

If you are a Surviving Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree, you are eligible for medical coverage under the Program as a DCC Non-Grandfathered Retiree. If you are a surviving Dependent Child of a DCC Non-Grandfathered Retiree, you are eligible for medical coverage under the Program as a Dependent Child of a DCC Non-Grandfathered Retiree until you cease to be a Dependent Child (generally, until you turn age 26); provided the Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program and you meet eligibility requirements described in *Section 9.5 Surviving Children*. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.

Depending on whether the Surviving Spouse of Record/Domestic Partner of Record is covered under another health plan at the time of the Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be restricted in which Dow Plan he or she may enroll.

If a Surviving Spouse of Record/Domestic Partner of Record is employed full-time or is retired, and is eligible for employer-sponsored health coverage (including from a former employer), the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that coverage in order to obtain coverage under the Program.

If you are a Surviving Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree who died prior to January 1, 2017, you are eligible for the Full Subsidy described above in *Section F-1.3 DCC Retiree Premiums and Employer Subsidy*. If you are a Surviving Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree who died on or after January 1, 2017, you are eligible for the subsidy the DCC Non-Grandfathered Retiree would have received under *Section F-1.3 DCC Retiree Premiums and Employer Subsidy*.

At age 65, if the Surviving Spouse of Record/Domestic Partner of Record becomes eligible to participate in the HRA Plan and the Aon Retiree Health Exchange ("Exchange"), as described in *Section F-1.2 Special Eligibility Rules if You or Your Dependents Are Eligible for Medicare* above, the Surviving Spouse of Record/Domestic Partner of Record may be eligible to receive a contribution to a health reimbursement arrangement ("HRA") under the HRA Plan that he or she can use towards the purchase of medical coverage on the Exchange. See the summary plan description for the HRA Plan for more information about eligibility for the HRA. For more information about the Exchange, contact the Retiree Service Center.

Section F-2. Certain Disabled Individuals of DCC

F-2.1. Eligible for Long Term Disability

Certain disabled individuals of DCC 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 F-2.1, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as a Retiree, unless otherwise stated.

Disabled on or after January 1, 2017

If you were a DCC Employee and your date of "full disability" (as defined under LTD) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends prior to 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 DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for medical coverage until you are no longer eligible to receive payments from LTD.
- You will be required to pay the same premiums Employees pay.

Disabled before January 1, 2017

If you are a DCC LTD Participant:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for medical coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).
- You will be required to pay the same premiums Employees pay.

You will be considered "retired," and thus ineligible for the Program as a DCC LTD Participant as follows:

Age Became Disabled	Date Considered "Retired"
Less than 60	Date reach age 65
60-64	Date that is 5 years after received first payment under the DCC LTD Plan
65-68	Date reach age 70
69 or older	Date that is 12 months after received first payment under the DCC LTD Plan

If you are no longer eligible for medical coverage as a DCC LTD Participant, you *may* be eligible as a DCC Retiree. See *Section F-1. DCC Retirees* above.

F-2.2 Survivor Benefits

Disabled on or after January 1, 2017

If you were a DCC Employee and your date of "full disability" (as defined under LTD) is on or after January 1, 2017, Survivor benefits are determined as follows:

- If the deceased LTD Participant was hired by DCC on or after January 1, 2006, or had less than ten years of DCC Service, and dies while still eligible for the 12- or 24-month period of medical coverage during which the LTD Participant pays Employee premiums, the Surviving Spouse of Record/Domestic Partner of Record may continue coverage at the 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, the Surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules.
- If the deceased LTD Participant was hired by DCC before January 1, 2006, and had ten (10) or more years of DCC Service at the time LTD payments commenced, and dies while still eligible for medical coverage, the Surviving Spouse of Record/Domestic Partner of Record is eligible for coverage under the same rules that apply to active employee deaths.

Disabled before January 1, 2017

If the deceased individual is a DCC LTD Participant, the Surviving Spouse of Record/Domestic Partner of Record and Dependent Child(ren) are eligible for coverage under the same rules that apply to active employee deaths. See "Surviving Dependent of Deceased DCC Employee" in *Section F-1.4 Survivor Benefits* above. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.