Summary Plan Description for:

The Dow Chemical Company Insured Health Program's

Vision Plan

(ERISA Plan #601)

APPLICABLE TO ELIGIBLE ACTIVE EMPLOYEES & ELIGIBLE RETIREES

Effective January 1, 2017 and thereafter until superseded

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.

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Section 1. ERISA Information

Summary Plan Description for The Dow Chemical Company Insured Health Program's Vision Plan	
Type of Plan	Group health plan
Type of Plan Administration	Benefits provided under an insured arrangement with the Vision Service Plan Insurance Company ("VSP"), the insurer of the Plan.
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
Employer Identification Number	38-1285128
Plan Number	601
Plan Administrator	North America Health and Insurance Plans Leader The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641 (877) 623-8079
Dow HR and Retiree Service Centers	*Active employees*: The Dow Chemical Company 2511 E. Patrick Road Midland, Michigan 48674 (877) 623-8079 *Retirees*: Dow Benefits Service Center – Coverage Compliance P.O. Box 5807 Hopkins, MN 55343 (800) 344-0661
Claims Administrators for Claims for Plan Benefits	*To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits*: VSP PO Box 385018 Birmingham, AL 35238-5018
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 insurer*: VSP PO Box 385018 Birmingham, AL 35238-5018
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 contributions are generally made through payroll deduction. Retirees pay the full cost of coverage. Retiree contributions are paid directly to VSP. Benefits are underwritten by VSP. VSP is liable to pay the benefits, not the Company or any Participating Employer. The assets of the Program, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.

Section 2. Introduction

This is the Summary Plan Description ("SPD") for the Vision Plan (the "Plan") offered under The Dow Chemical Company Insured Health Program (the "Program") as applicable to eligible Employees, Retirees, LTD Participants, DCC LTD Participants, and certain other former Employees.

This SPD, together with the materials provided by the Plan, is intended to constitute the "Summary Plan Description" ("SPD") for the Plan.

The Plan is governed by the plan document for the Program, which is the legal instrument under which the Program is operated. This legal instrument is referred to in this SPD as the "Plan Document." If there is any inconsistency between this SPD and the Plan Document, the Plan Document shall govern unless explicitly stated otherwise.

This SPD contains important information about benefits under the Plan. However, it does not contain all of the information. Further information can be found in the Plan Document. You may request a copy of the Plan Document 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 Program (and any of the Plans offered under the Program) at any time in its sole discretion.

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

Capitalized words in this SPD are defined in the Plan Document, in *Section 29. Definitions of Terms*, in the materials provided by the 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.

Section 3. About the Plan

3.1 Dow and the Plan

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

3.2 Information that VSP Should Provide You

VSP will supply you, upon written request, written materials concerning:

- the nature of services provided under the Plan;
- conditions pertaining to eligibility to receive such services, other than general conditions pertaining to eligibility required by Dow described in this SPD; and
- the circumstances under which services can be denied.

3.3 Benefits

Appendix B of this SPD contains the Description of Plan Benefits.

Section 4. Eligibility

4.1 Eligibility for Employees

As explained in this section of the SPD, the Plan provides coverage for certain Employees.

Employee Eligibility

You are eligible for vision coverage under the Plan 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 Plan. However, if the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Plan, 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 the Plan.

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 Plan 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 Plan shall be administered consistent with the terms of such approved leaves of absences.

Severance Agreement

You may be eligible to participate in the Plan 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 Plan will be governed by the terms of the applicable severance plan documents or agreement.

4.2 Eligibility for Retirees and Certain Former Employees

As explained in this section of the SPD, the Plan provides coverage for certain Retirees, disabled individuals, and other former Employees.

Retirees

The Plan is applicable to eligible Retirees as described in *Section 29. Definition of Terms*.

Certain Disabled Individuals

Certain disabled individuals are eligible for coverage under the Plan. In general, to the extent that you are eligible for coverage under the Plan as one of the disabled individuals described in this section, your participation in the Plan 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 4.2 of the SPD.

Long Term Disability Participants (other than DCC Employees and Employees of Rohm and Haas LTD Participants)

If you (i) were not a DCC Employee, (ii) are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and (iii) have been approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), you are eligible for coverage under the Plan under the following circumstances:

- 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:
    - If you either 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 vision 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 vision coverage under the Plan until you are no longer eligible to receive payments from LTD.
    - You will be required to pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).
- If your date of "full disability" (as defined under LTD) is prior to January 1, 2006, the following applies to you:

    You are eligible for vision coverage under the Plan until you are no longer eligible to receive payments from LTD. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

Disability Retirees under Dow Employees' Pension Plan

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. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

Disability Retirees under Union Carbide Employees' Pension Plan

If you have been approved for disability retirement benefits under the UCEPP component of the Union Carbide Employees' Pension Plan on or after February 7, 2003, 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 UCEPP component of the Union Carbide Employees' Pension Plan. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

Rohm and Haas LTD Participants

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan and you have been approved to receive benefit payments under The Dow

Chemical Company Long Term Disability Program ("LTD"), your eligibility for coverage under the Plan begins when your LTD benefit payments begin, and the following rules apply:

- If you were hired by Rohm and Haas before January 1, 2003, and you have ten (10) or more years of Service, the following applies to you:
    - You are eligible for coverage under the Plan until you are no longer eligible to receive payments from LTD.
    - You will be required to pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).
- If you were hired by Rohm and Haas on or after January 1, 2003, or you have less than ten (10) years of Service, the following applies to you:
    - You are eligible for up to either 12 months or 24 months of vision coverage. Coverage ends before the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have one (1) year of Service or more.
    - You will be required to pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

Hampshire Long Term Disability Participants

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 Plan for as long as you continue to be approved by UNUM to receive benefit payments from that long term disability plan. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/). Eligibility for vision 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 Plan. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

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 Plan. You pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

DCC Long Term Disability Participants

Certain disabled individuals of DCC are eligible for coverage under the Plan.

- If you were a DCC Employee and your date of "full disability" (as defined under LTD) is on or after January 1, 2017, the following applies to you:
    - You are eligible for coverage under the Plan 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 vision 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 vision coverage until you are no longer eligible to receive payments from LTD.
- You are required to pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

- If you are a former DCC Employee who was disabled under the DCC LTD Plan on December 31, 2016 (a DCC LTD Participant), the following applies to you:
  - You are eligible for coverage under the Plan effective January 1, 2017.
  - You are eligible for coverage as a DCC LTD Participant until the date you are no longer eligible to receive payments from LTD.
  - You are required to pay the full cost of coverage to VSP. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

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 Plan 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 Plan.

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 Plan, 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 Plan 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 A Mergers, Acquisitions and Other Special Situations*. Contact the Retiree Service Center for more information

4.3 Dependent Eligibility

Eligible Employees and Retirees (and other Participants eligible for coverage under Sections 4.1 or 4.2 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 4.2 of this SPD, Spouse of Record/Domestic Partner of Record), or an eligible Dependent Child. You must be enrolled in order to enroll a Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) or Dependent Child.

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 Plan 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 4.1 of this SPD), your new Spouse or Domestic Partner is NOT eligible for coverage under the Plan.

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 the Plan.

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 Plan if he or she is an Employee and you are a Retiree. See *Section 5.4 Dual Dow Coverage*.

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

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 Plan if the coverage offered by his or her employer is as comprehensive as or better than the Plan's. The Plan would generally be secondary to your Spouse's/Domestic Partner's (or Spouse of Record's/Domestic Partner of Record's) vision plan under the Dow coordination of benefits rules. You may choose to waive coverage for your Spouse/Domestic Partner (or Spouse of Record/Domestic Partner of Record) under the Plan in order to save premium dollars. If you waive coverage under the Plan, then no coordination of benefits will occur.

Dependent Child(ren)

A child is eligible for coverage under the Plan 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 vision coverage under the vision 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 the Plan Administrator. 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 vision 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 medical coverage prior to March 1, 2013, and remains continuously covered under Dow medical coverage through December 31, 2015 and Dow vision coverage on or after January 1, 2016.

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 5. Employee Enrollment* or *Section 6. Retiree Enrollment*, as applicable, you submit proof at the time of enrollment that the child was covered as a dependent under his 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 vision 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 *13.2 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 eligible Employee or Retiree (or other individual eligible for coverage under Sections 4.1 or 4.2 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 the Plan. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Plan.

Typically, a divorce decree that orders the Employee or Retiree (or other individual eligible for coverage under Sections 4.1 or 4.2 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 or 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 or 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 or Retiree or custodial parent, the Program reserves the right to require the Employee or Retiree (or other Participant) and/or custodial parent to obtain a court order to resolve the ambiguity.

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

4.4 International Medical and Dental Plan Exclusion

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

4.5 Eligibility Determinations of Claims Administrator Are Final and Binding

The applicable Claims Administrator determines eligibility. The Claims Administrator is a fiduciary of the Program and has 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 26. Claims Procedures*.

Section 5. 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 4.1 of this SPD).

5.1 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 the Plan in order to enroll your Dependent Spouse/Domestic Partner or Dependent Child in the Plan.

5.2 Enrolling at the Beginning of Employment

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

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

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

If you do not enroll within 90 days of your date of hire, you will not have coverage, and you will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 7. 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 first day at work. 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. *If you do not submit proof of Dependent eligibility by the 30-Day Deadline, you will not be eligible to enroll the Dependent until the next applicable enrollment period.*

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 12. Fraud Against the Program*.

5.3 Enrolling During Annual Enrollment

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

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

If you wish to add a Dependent – either a Spouse/Domestic Partner or a child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. **You must provide proof of Dependent eligibility no later than 90 days after the start of the applicable Plan Year (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. *If you do not provide proof of Dependent eligibility by the 30-Day Deadline, you will not be eligible to enroll the Dependent until the next applicable enrollment period.*

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 12. Fraud Against the Program*.

If your Spouse is enrolled in the 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 *13.2 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 vision plan elections will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible for the coverage in which you are enrolled.

5.4 Dual Dow Coverage

If you and your Spouse/Domestic Partner are each independently eligible for coverage under the Plan, the following rules apply:

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

5.5 Change of Elections to Prevent Discrimination

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

Section 6. Retiree Enrollment

This section of the SPD describes the enrollment rules applicable to Retirees (as well as those Participants eligible for coverage under Section 4.2 of this SPD).

6.1 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 the Plan in order to enroll your Spouse of Record/Domestic Partner of Record or Dependent Child in the Plan.

6.2 Enrolling at Retirement

To enroll for Plan coverage upon your Retirement, enroll within 31 days after your Retirement on the VSP web site (dowretirees.vspforme.com) or by calling VSP at 1-800-400-4569. If you do not enroll yourself and/or your eligible Dependents within 31 days after Retirement, you and/or they will not be covered. You will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 7. Mid-Year Election Changes*).

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 VSP. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers, or any other proof VSP deems appropriate. *If you do not provide proof of Dependent eligibility within the timeframe required by VSP, you will not be eligible to enroll the Dependent until the next applicable enrollment period.*

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 12. Fraud Against the Program*.

6.3 Retiree Annual Enrollment

Annual enrollment is typically held during the last quarter of the year and is handled electronically. Subject to the eligibility rules, 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.

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 may be required to 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 VSP deems appropriate. If proof of Dependent eligibility is requested and you do not provide proof 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.

If you do not provide proof of Dependent eligibility by the 30-Day Deadline, you will not be eligible to enroll the Dependent until the next applicable enrollment period.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 12. Fraud Against the Program*.

If your Spouse of Record is enrolled in the 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 *13.2 COBRA Continuation 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 vision plan elections will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible for the coverage in which you are enrolled.

6.4 Dual Dow Coverage

If you and your Spouse of Record/Domestic Partner of Record are each independently eligible for coverage under the Plan, the following rules apply:

- You may each enroll separately, or one of you may enroll the other as a Dependent.
- 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.)

Section 7. 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 5. Employee Enrollment* and pay premiums on a pre-tax basis, unless you meet the requirements of this Section 7. This Section 7 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 4. Eligibility*.

Regardless of whether you are a Retiree or an Employee, you may generally change your enrollment in the Plan or change your level of participation (*e.g.*, Employee Only, Employee Plus Spouse, or Family) as follows:

- During annual enrollment, you may make any change to your participation in the Plan, including enrolling or disenrolling in the Plan, or changing your level of Participation by adding or dropping Dependents.
- If you have a special enrollment event described in *7.1 Special Enrollment Provisions* or another permissible change event described in *7.4 Other Permissible Changes*, you may enroll or increase your level of participation 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 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 Plan as a result of the event.

If you are a **Retiree** (or other Participant eligible for coverage under Section 4.2 of this SPD), you may also **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).

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 Plan.

7.1 Special Enrollment Provisions

You may be eligible to enroll yourself and/or a Dependent in the Plan outside of annual enrollment if one of the following special enrollment events occurs:

- ***Loss of Other Vision Coverage***. If you decline enrollment in the Plan for you or your Dependent(s) (including your Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record) because you have other vision 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 Plan, you or your eligible Dependent must enroll in the Plan within 90 days after the other coverage ends. However, if you or your Dependent declined Dow-sponsored coverage because of other coverage provided through COBRA, you or your Dependent must wait until the annual enrollment period unless the entire period of coverage available under the COBRA coverage has been exhausted. An individual need not elect COBRA coverage under another health plan in order to use these special enrollment provisions.
- ***Marriage, Birth, or Adoption***. Subject to the eligibility rules in *Section 4.3 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 Plan 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 Plan because of a special enrollment event described above, you must provide proof of the event in accordance with *7.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *7.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *7.7 Deadline to Enroll for Mid-Year Changes*.

7.2 Change in Status

For Employees (and other Participants Eligible Under Section 4.1 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.
- A change in the place of residence or work for you or your Spouse/Domestic Partner or Dependent Child.

- Your Dependent satisfies or ceases to satisfy the definition for "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 4.2 of this SPD)

For Retirees (and other Participants eligible under Section 4.2 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

7.3 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 Plan 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 Plan must ***correspond with*** that gain or loss of coverage.

7.4 Other Permissible Changes

You may change your enrollment in the 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 vision plan election.
- ***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 Plan 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 the Plan mid-year if you meet, and to the extent permitted by, the special enrollment requirements addressed in *7.1 Special Enrollment Provisions*.

7.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated change you are permitted to make. 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.

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll or you may increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse).
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 cancel your participation.
Spouse/Domestic Partner loses vision coverage elsewhere	You may enroll or increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse).

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

In general, you are required to provide proof of eligibility to make 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. If you do not submit

such proof by the 30-Day Deadline, you will not be eligible to enroll the Dependent until the next applicable enrollment period.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 12. Fraud Against the Program*.

Dropping an Ineligible Dependent

If a Dependent becomes ineligible for the Plan, you are required to update your enrollment information on the Dow Benefits web site or notify the HR Service Center or VSP, as applicable, as explained in *Section 4.3 Dependent Eligibility*. If you fail to timely notify Dow or VSP, as applicable, 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 vision 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

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.

7.7 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the fall of each year), you must submit the required proof of eligibility in accordance with *Section 7.6 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).

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 8. Employee Premiums

8.1 Your Contribution

If you are an Employee, you and Dow share the premium costs for your vision coverage. Your contributions to premiums are paid through payroll deductions. For your portion of the monthly premium, refer to the materials provided during the annual enrollment period. The amount you pay is the difference between the total cost of VSP coverage and Dow's contribution to the premium costs.

If you are an Employee, contributions for coverage for you, your Spouse and/or your Dependent Child(ren) are deducted on a pre-tax basis through the Dow Flexible Spending Plan, a Plan intended to qualify under Section 125 of the Code as a "cafeteria plan." 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.

8.2 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 vision 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 vision coverage, you must first reimburse the Plan for any unpaid premiums you owe.

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

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

8.3 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.

8.4 Premiums During a Benefits Protected Leave of Absence

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

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

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

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

8.5 Premiums for LTD Participants

If you are a LTD Participant, you pay the premium costs for your vision coverage. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

You will pay your premiums directly to VSP as they become due. Your failure to pay the full amount of premiums due by the date required by VSP may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. VSP, in its sole discretion, may determine whether you are delinquent in paying premiums. VSP reserves the right to require you to pre-pay premiums in order to receive coverage.

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

Section 9. Retiree Premiums

If you are a Retiree, you pay the premium costs for your vision coverage. For the monthly premium, refer to the materials posted on the Dow Friends website (http://www.dow.com/friends/benefits/).

You will pay your premiums directly to VSP as they become due. Your failure to pay the full amount of premiums due by the date required by VSP may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. VSP, in its sole discretion, may determine whether you are delinquent in paying premiums. VSP reserves the right to require you to pre-pay premiums in order to receive coverage.

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

Section 10. Survivor Benefits

10.1 General Rule

In general, a Surviving Spouse/Domestic Partner of an active Employee or Retiree is eligible for vision coverage to the same extent and for the same duration as the Surviving Spouse/Domestic Partner is eligible for medical coverage under a medical plan sponsored by Dow or one of its subsidiaries; provided, however, that the Surviving Spouse/Domestic Partner's vision coverage will not end merely because the Surviving Spouse/Domestic Partner turns age 65. See *13.2 COBRA Continuation Coverage*.

10.2 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.[1] 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 or Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record may not enroll for coverage.

10.3 Surviving Children without Surviving Spouse/Domestic Partner

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"). They will be offered 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.*

Section 11. Notice Required by Law

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the following notice:

Information Exchanged by the Program's Business Associates

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

[1] 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.

Section 12. 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, 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 13. Ending Coverage

13.1 When Coverage Ends

Except as otherwise provided in this Section 13.1, 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 Plan
- Providing false or misleading information to the Program or the Plan

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 Plan due to a termination of employment, your coverage terminates on the last day of your 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 *13.2 COBRA Continuation Coverage*); or
- is eligible to participate after your death in accordance with *Section 10. Survivor Benefits*.

13.2 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 Plan 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 Plan 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 Plan's definition and rules concerning Domestic Partners, and to the extent that it does not jeopardize the tax qualified status of the Plan.

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

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

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"):

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

What Is COBRA Continuation Coverage?

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

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

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

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced (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 *13.2 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 Plan because of any of the following qualifying events:

1. The parent-Employee or parent-Retiree dies;
2. The parent-Employee's hours of employment are reduced (only applicable to active Employees working for a Participating Employer);
3. The parent-Employee's employment ends for any reason other than his or her gross misconduct (only applicable to active Employees working for a Participating Employer);
4. The parent-Employee or parent-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 Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee or 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 the 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 14. Your Legal Rights Under ERISA

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

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

applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

- Continue health care coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents must pay for such coverage. For more information, see *13.2 COBRA Continuation Coverage*.

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Program fiduciaries misuse the Program's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. For more information regarding enforcing your rights in court, see *Section 19. Litigation and Class Action Lawsuits*.

Assistance with your questions: If you have any questions about the information in this SPD or an eligibility for coverage question, you should contact the Plan Administrator. If you have a question about the benefits covered, or the terms and conditions for receiving benefits, network providers, etc., you should contact the Plan. For the contact information for the Plan Administrator and the 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 26. Claims Procedures*.

Section 16. Plan Document

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

Section 17. No Government Guarantee of Welfare Benefits

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

Section 18. Dow's Right to Terminate or Amend the Program

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

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

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

Section 19. Litigation and Class Action Lawsuits

19.1 Litigation

If you wish to file a lawsuit against the Program or the Plan (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures described in *Section 26. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA. (A lawsuit against the Plan is considered a lawsuit against the Program of which the Plan is a part, for purposes of this SPD.)

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

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

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

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

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

19.2 Class Action Lawsuits

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

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

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

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

Section 20. Incompetent and Deceased Participants

If the Administrator determines that you or your Dependent is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan, the Administrator may make benefit payments to the court-appointed legal guardian for you or 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, 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, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his Advisors with respect to whom a privilege applies, unless mandated by a court order.

Section 22. Waivers

A term, condition, or provision of the Program shall not be waived unless the purported waiver is in writing signed by the Plan Administrator. A written waiver shall operate only as 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 Employees. Retirees pay full premium costs. Employee contributions are generally made through payroll deduction. Retiree contributions are paid separately by the Participant. Benefits are underwritten by the Plan. The Plan is an insured plan under ERISA.

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

Section 25. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program or Plan were provided to, or on behalf of, a Participant 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, or his estate.

Section 26. Claims Procedures

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

- A *Claim for Plan Benefits* is a Claim requesting that the Plan pay for benefits covered under the 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 *Section 26.5 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

26.1 Deadline to File a Claim

All Claims must be filed within 365 calendar days from the date that the service was rendered. The deadline for filing a Claim that you were overcharged for coverage is the end of the year following the year for which the premium was paid. Failure to file a Claim within the deadline will result in denial of the Claim.

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

The Program has more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you 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 VSP.

- *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 26. Claims Procedures* (or the Claims Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *19.1 Litigation* for the deadline for filing a lawsuit.

26.3 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Participant. The Plan will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Plan. In the case of a Claim for Plan Benefits that is an Urgent Care Claim, a health care professional with knowledge of your condition also may act as your authorized representative.

26.4 How to File a Claim for Plan Benefits

The procedures described below for Initial Determination, Initial Appeal, and Second Level Appeal will apply in most circumstances to a Claim for Plan Benefits. But in certain situations, your Claim for Plan Benefits may receive special handling, as described at the end of this section.

All Claims for Plan Benefits should be sent to the Claims Administrator at the contact information provided in *Section 1. ERISA Information*.

Initial Determination

Generally, VSP will pay or deny Claims for Plan Benefits within thirty (30) calendar days of receipt. In the event that a Claim for Plan Benefits cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days. If your Claim for Plan Benefits is denied (partially or entirely), VSP will notify you in writing. Notwithstanding anything herein to the contrary, VSP shall pay or deny all Claims for Plan Benefits in accordance within the timeframes, and in the manner set forth under 29 C.F.R. 2560.503-1. The written notification will provide–

- the specific reason(s) your claim was denied;
- the relevant Plan provisions on which the denial was based;
- the procedures for filing an appeal and the applicable time limits (also described below), as well as a statement of your right to bring a civil action under section 502(a) of ERISA;

- if applicable, an explanation or copy of any internal rule, guideline, protocol, or similar criterion that was relied upon in making the decision to deny your claim;
- if applicable, an explanation of the scientific or clinical judgment applied in making a determination of medical necessity, experimental treatment, or similar exclusion or limit, or a statement that you may request such explanation at no cost; and
- if your claim was denied because VSP needed additional material or information, an explanation of the additional material or information that is needed; you will have at least forty-five (45) calendar days to provide the required information.

Claim Denial Appeals

If your Claim for Plan Benefits is denied in whole or in part, under the terms of the VSP insurance policy, you may submit a request for a full review of the denial.

Initial Appeal

The request for review of a Claim for Plan Benefits decision must be made in writing within one hundred eighty (180) calendar days following denial of a Claim for Plan Benefits and should contain sufficient information to identify yourself and the claim affected by the denial. You may request copies of documents, records, and other information that is relevant to the Claim for Plan Benefits. VSP will decide whether a document or record is relevant. You may also submit written comments or supporting documentation concerning the Claim for Plan Benefits to assist in VSP's review.

VSP will consider your appeal anew, without giving any deference to the initial decision to deny your Claim for Plan Benefits. VSP's response to the initial appeal will be provided and communicated to you within thirty (30) calendar days after receipt of your written appeal. If your appeal is denied (partially or entirely), the notification will provide–

- the specific reason(s) your appeal was denied;
- the relevant Plan provisions on which the denial was based;
- a statement that you may request, at no charge, copies of all documents, records, and other information relevant to your claim (VSP will decide whether a document or record is relevant);
- the procedures for filing a Second Level appeal, as well as a statement of your right to bring a civil action under section 502(a) of ERISA;
- if applicable, an explanation or copy of any internal rule, guideline, protocol, or similar criterion that was relied upon in making the decision to deny your appeal; and
- if applicable, an explanation of the scientific or clinical judgment applied in making a determination of medical necessity, experimental treatment, or similar exclusion or limit, or a statement that may can request such explanation at no cost.

Second Level Appeal

If you disagree with the response to the initial appeal of the denied Claim for Plan Benefits, you have the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, you may submit a second appeal to VSP along with any pertinent documentation. VSP will communicate its final determination to you in thirty (30) calendar days from receipt of the request and in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Special Handling Procedures

The procedures above for Claims for Plan Benefits will apply in most circumstances. In certain special situations, your Claim for Plan Benefits may be processed more quickly.

- *Urgent care claims*. A Claim for Plan Benefits will receive expedited handling if the ordinary time periods described above could seriously jeopardize your life or health or subject you to severe pain that cannot be adequately managed. You are not required to submit urgent care Claims for Plan Benefits in writing. VSP will notify you of its decision on an urgent care claim, either orally or in writing, within seventy-two (72) hours of receipt. If an urgent care claim is not filed properly or is missing information, VSP will notify you within twenty-four (24) hours and give you at least forty-eight (48) hours to provide the missing information. If your urgent claim is denied (partially or entirely), you may appeal this denial. The appeal procedures described above will apply, except that you may request review of an urgent claim denial either orally or in writing, and VSP will notify you of its decision, either orally or in writing, within seventy-two (72) hours. If VSP notifies you orally of a decision to deny an urgent care claim or appeal, VSP will send a written notice within three (3) calendar days of the oral notification.

- *Preauthorization*. If the Plan requires preauthorization for a covered service, VSP will approve or deny a preauthorization request within fifteen (15) calendar days of receipt. If necessary, VSP may extend this time by no more than fifteen (15) calendar days. VSP will notify you within five (5) calendar days if your request for preauthorization is not filed properly, or within fifteen (15) calendar days if your request is missing information; in either case, you will have at least forty-five (45) calendar days to provide the missing information. If your preauthorization request is denied (partially or entirely), you may request review of the denial by following the Initial Appeal and Second Level Appeal procedures above. VSP will decide an appeal of a preauthorization request denial within fifteen (15) calendar days of receipt.

- *Ending or extending a current course of treatment.* If the Plan decides to reduce or end coverage for a course of treatment that you are currently receiving under the Plan, you will be notified in advance and allowed to appeal the decision under the appeal process described above. VSP will decide an appeal of a decision to reduce or end coverage for a current course of treatment within fifteen (15) calendar days. If you request to extend a current course of treatment beyond what the Plan has previously authorized, VSP will approve or deny the request within twenty-four (24) hours of receipt.

26.5 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 for an Eligibility Determination":

- The name of the Retiree, Employee (or former Employee), and the name of the person (Employee, 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 Insured Health Program);
- If the eligibility determination is being requested for the Retiree's or Employee's dependent:
    - a description of the relationship of the dependent to the 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 Insured Health Program (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;
- 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 Insured Health Program);
- Reference to the initial determination; and
- An explanation of the reason why you are appealing the initial determination.

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

North America Health and Insurance Plan Manager
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, Michigan 48641
Attention: Appeals Administrator for The Dow Chemical Company Insured Health Program (Claim for 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 27. Tax Consequences of Coverage and Benefits

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

Section 28. No Assignment of Benefits

In general, except to the extent required by law or otherwise provided in the Plan Document or SPD, benefits payable under the Program shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or change of any kind. You may direct that benefits payable to you be paid instead to a provider or to a person who has agreed to pay for any benefits payable under the Program. The Program reserves the right to make payment directly to you, however.

Section 29. Definitions of Terms

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

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 VSP. 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.

Claim
A written request by a claimant for a Plan benefit, or for an eligibility determination, that contains, at a minimum, the information described in *Section 26. Claims Procedures*.

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

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

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

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.

Copayments
Those amounts required to be paid by or on behalf of a Participant for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

DCC
Dow Corning Corporation.

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 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.

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, 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 4.3 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 is also your birth or adopted child (or a child for whom you are the legal guardian) (as explained above).

If you had vision coverage under the vision 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 the Plan Administrator. 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 vision 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 4.2 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 active 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 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 Retiree Medical Care Program" or "Retiree Medical Program"

The Dow Chemical Company Retiree Medical Care Program.

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

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

HIPAA
The Health Insurance Portability and Accountability Act.

Initial Claims Reviewer
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is VSP. 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 Plan, is enrolled in coverage under the Plan, and remains eligible for benefits under the Plan.

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

Open Access Provider
Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

Participant
An Employee, 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 Plan, elects to participate in the Plan, and remains eligible for benefits under the Plan.

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. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the

Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan
The Vision Plan.

Plan Benefits
The vision care services and vision care materials which a Participant is entitled to receive by virtue of coverage under the VSP insurance policy.

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 the Program, which is ERISA Plan #601. The summary plan description for the Plan offered under the Program is an integral part of the Plan Document.

Points
The sum of a person's age and Service.

Program
The Dow Chemical Company Insured Health Program.

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

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

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

Retiree
Notwithstanding anything to the contrary in the definition of "Retiree" in the Plan Document, Retiree means one of the following:

- A "Retiree" or "DCC Retiree" who is eligible for medical coverage under The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program;
- A "Retiree" who is eligible for medical coverage under the Union Carbide Corporation Retiree Medical Care Program or the Union Carbide Corporation Retiree Insured Health Program; or
- A "Retiree" who is eligible for medical coverage under the Rohm and Haas Company Health and Welfare Plan;

provided that in each case, the Retiree or DCC Retiree shall remain eligible for the Plan after becoming eligible for Medicare.

Salaried
Not represented by a collective bargaining unit.

Service

For those who are eligible to participate in the Dow Employees' Pension Plan and were hired by a participating employer (other than Dow Corning) of the Dow Employees' Pension Plan prior to January 1, 2008, "Service" means "service" as defined under Dow Retiree Medical Care Program. For those who are eligible to participate in the Dow Employees' Pension Plan and were hired by a participating employer (other than Dow Corning) of the Dow Employees' Pension Plan on or after January 1, 2008, "Service" means "service" as defined under the Dow Retiree Medical Care Program.

For those who are eligible to participate in the Union Carbide Employees' Pension Plan and were hired by a participating employer of the Union Carbide Employees' Pension Plan prior to January 1, 2008, "Service" means "service" as defined under Union Carbide Retiree Medical Care Program. For those who are eligible to participate in the Union Carbide Employees' Pension Plan and were hired by a participating employer of the Union Carbide Employees' Pension Plan on or after January 1, 2008, "Service" means "service" as defined under the Dow Retiree Medical Care Program.

For those who are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan and were hired by a participating employer of the Rohm and Haas Company Retirement Plan prior to April 1, 2009, "Service" means "service" as defined under the Rohm and Haas Company Health and Welfare Plan. (Note that the Rohm and Haas Company Retirement Plan was closed to new hires as of April 1, 2009. Rohm and Haas Company became a participating employer of the Dow Employees' Pension Plan with respect to new hires on and after April 1, 2009).

For Americas Styrenics employees, the Plan recognizes service with Chevron-Phillips Chemical immediately prior to Americas Styrenics employment.

For Employees of Dow Corning who are actively at work on or after January 1, 2017, "Service" is 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.

Spouse

A person who is Married to an Employee, 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 4.3 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 4.3 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 active Employee, "Spouse of Record" means the Spouse of such Participant (if any) as of the date of the Participant's death.

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

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 Plan, including its appendices. The Summary Plan Description is an integral part of the Plan Document for The Dow Chemical Company Insured Health Program.

Surviving Spouse/Domestic Partner
The widowed Spouse/Domestic Partner of an active Employee who participated in the Plan at the time of death of the Employee.

Surviving Spouse of Record/Domestic Partner of Record
The widowed Dependent Spouse of Record/Domestic Partner of Record of a Retiree (or any other Participant eligible for coverage under Section 4.2 of this SPD) who participated in the Plan, 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); 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.

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.

VSP
The Vision Service Plan Insurance Company.

VSP Preferred Provider
An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Participants.

Section 30. 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 SPD, together with the materials provided by the Plan, is intended to constitute the Summary Plan Description ("SPD") for the Plan, offered under The Dow Chemical Company Insured Health Program (the "Program"). However, this SPD is not all-inclusive and it is not intended to take the place of the Program's legal documents.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (including the Plan) at any time in its sole discretion.

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

Appendix A. MERGERS, ACQUISITIONS AND OTHER SPECIAL SITUATIONS

If you are a former employee and were a part of one of the entities listed below, the Plan Document provides special rules regarding your eligibility under the Program. (The Plan Document incorporates by reference the special rules in Section 3.1 of the plan document for 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

Appendix B. DESCRIPTION OF PLAN BENEFITS

Description of Plan Benefits for Vision Plan