Summary Plan Description for:

The Dow Chemical Company
Retiree Medical Care Program's

Health Reimbursement Arrangement for
DCC Non-Grandfathered Retirees

(ERISA Plan #501)

APPLICABLE TO ELIGIBLE
DCC NON-GRANDFATHERED RETIREES

Amended and Restated
Effective January 1, 2017 and thereafter until superseded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 Dow Retiree Service Center by calling 800-344-0661, 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 Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees** ***Applicable to Eligible DCC Non-Grandfathered Retirees***	
Type of Plan	Group health plan
Type of Plan Administration	Health Reimbursement Account in connection with Aon Retiree Health Exchange
Plan Administrator	North America Health and Insurance Plans Leader The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641 (800) 344-0661
Employer Identification Number	38-1285128
Plan Number	501
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, Michigan 48641
Retiree Service Center	Dow Benefits Service Center – Coverage Compliance P.O. Box 5807 Hopkins, MN 55343 (800) 344-0661
Claims Administrator for Claims for Plan Benefits	*To submit a Claim for Plan Benefits or appeal a denied Claim for Plan Benefits:* Your Spending Account Service P.O. Box 64030 The Woodlands, TX 77387-4030 (844) 572-3442 Aon (888) 628-0082

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 (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
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	Benefits are paid from the Company's general assets. 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.

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

Section 2. Introduction

This is the Summary Plan Description ("SPD") for the Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees, offered under The Dow Chemical Company Retiree Medical Care Program (the "Program"). The provisions of this SPD apply to eligible DCC Non-Grandfathered Retirees.

In this SPD, the Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees is referred to as the "Plan." In addition to the Plan, Dow offers other medical plans under the Program. Check www.dowfriends.com or call the Retiree Service Center at (800) 344-0661 for information about other plans that may be available to you.

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.

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 for the Program. 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 28. Definitions of Terms* 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. Eligibility

As explained in this section of the SPD, the Plan provides coverage for certain DCC Non-Grandfathered Retirees, as well as certain dependents. Survivor eligibility is summarized in *Section 7. Survivor Benefits*.

3.1 Eligibility for DCC Non-Grandfathered Retirees

The Plan is applicable to eligible DCC Non-Grandfathered Retirees.

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

If you were a DCC Employee, you may be eligible for coverage under the Plan if you are a DCC Non-Grandfathered Retiree.

- A "DCC Non-Grandfathered Retiree" is—

    1. A DCC Employee who (1) was hired by DCC before January 1, 2006, (2) is age 50 or older with 10 years of DCC Service on the day preceding Retirement, and (3) was

eligible to participate in the DCC health and welfare plan for active employees, The Dow Chemical Company Medical Care Program, or The Dow Chemical Company Insured Health Program (except The Dow Chemical Company International Medical and Dental Plan) on the day preceding Retirement; or

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

Subject to *Section 3.3 Special Eligibility Rules If You or Your Dependents Are Not All Eligible for Medicare*, if you are a DCC Non-Grandfathered Retiree as summarized above, you are eligible for coverage under the Plan if you meet *all* of the following requirements:

- You are Eligible for Medicare;
- You have enrolled in Medicare Parts A and B, or a Medicare Advantage plan purchased either through the Aon Retiree Health Exchange (the "Exchange") or separately; and
- You purchase a Medicare supplement (Medigap) plan and/or Medicare prescription drug plan (Part D), or Medicare Advantage plan through the Exchange for the applicable Plan Year.

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

3.2 Dependent Eligibility

Subject to *Section 3.3 Special Eligibility Rules If You or Your Dependents Are Not All Eligible for Medicare*, eligible DCC Non-Grandfathered Retirees can enroll their eligible Dependents in the Plan. A Dependent may be either your Spouse of Record or your Domestic Partner of Record, or an eligible Dependent Child. You must be enrolled in the Program or The Dow Chemical Company Insured Health Program in order to enroll a Spouse of Record/Domestic Partner of Record or Dependent Child in this Plan. If you are not eligible to participate in this Plan, but you are eligible to participate in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program, such as The Retiree MAP Plus Option 1 Low Deductible Plan, which is a plan within the Program, you must be enrolled in that plan in order to enroll your Dependent(s) in this Plan. To be eligible a Dependent must meet *all* of the following requirements:

- The Dependent is Eligible for Medicare;
- The Dependent has enrolled in Medicare Parts A and B, or a Medicare Advantage Plan purchased either through the Exchange or separately; and
- The Dependent purchases a Medicare prescription drug and/or Medicare supplement plan from the Exchange for the applicable Plan Year. The Dependent can purchase a Medicare supplement (Medigap) plan, Medicare Advantage plan, or Medicare Part D plan through the Exchange.

If your Dependent is eligible for Medicare, he or she should enroll in Medicare Parts A and B, or a Medicare Advantage Plan, and he or she should consider enrolling in Medicare Part D. (Note: You and your Dependents are not eligible to enroll in a Medicare Advantage Plan offered under The Dow Chemical Company Insured Health Program.) Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.

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

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

Spouse of Record/Domestic Partner of Record

Your Spouse of Record/Domestic Partner of Record is generally your Spouse or Domestic Partner as of your Retirement. If you marry, remarry or enter into a new Domestic Partnership after Retirement (or after otherwise meeting the eligibility requirements under Section 3.1 of this SPD), your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow-sponsored retiree medical program. However, if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married.

Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement, and the exception described above does not apply, your new Spouse's or Domestic Partner's children (*e.g.*, your step-children) who are not your birth or legally adopted children are not generally eligible for coverage under any Dow-sponsored retiree medical program.

Spouse of Record/Domestic Partner of Record also includes spouses/domestic partners of DCC Non-Grandfathered Retirees 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 of Record/Domestic Partner of Record Exclusions

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

- Eligible for subsidized coverage as a full-time employee or retiree under another employer's plan, but not enrolled for personal coverage in that plan or not enrolled in Medicare (if he or she is eligible for Medicare).[1] (See *Working or Retired Spouse of Record/Domestic Partner of Record Rule*, immediately below for details.);
- An Employee, or enrolled for coverage as an Employee, Retiree, or DCC Retiree (or other former Employee) under another Dow or Dow-affiliated medical plan (see *Section 4.5 Dual Dow, DCC, UCC, or ROH Coverage*); or
- Serving in the armed forces of any country.

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

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

If your Spouse of Record/Domestic Partner of Record is working full time or is retired and his or her employer (or former employer) offers subsidized employer-sponsored health coverage to its employees or retirees, he or she may not be covered as a Dependent under the Plan unless he or she has enrolled in the employer-sponsored health coverage. This rule applies no matter how large or small the subsidy offered by your Spouse of Record's/Domestic Partner of Record's employer is or what the premiums are. If your

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

Spouse of Record's/Domestic Partner of Record's employer offers more than one type of health coverage (*e.g.*, more than one group health plan), your Spouse of Record/Domestic Partner of Record must enroll in the coverage that is most comparable to the Plan.

If your Spouse of Record/Domestic Partner of Record has coverage through his or her employer, as described in the preceding paragraph, and your Spouse of Record/Domestic Partner of Record fails to enroll in appropriate coverage available through his or her own employer (or former employer), you will not be able to enroll the Spouse of Record/Domestic Partner of Record until the next applicable enrollment period, provided your Spouse of Record/Domestic Partner of Record satisfies the Plan's eligibility requirements.

Additional or alternative actions might be taken on account of your or your Spouse of Record's/Domestic Partner of Record's fraudulent actions or inactions or intentional misrepresentation. See *Section 9. Fraud Against the Program*.

There is no requirement for your Spouse of Record/Domestic Partner of Record to enroll your Dependent Child(ren) in your Spouse of Record's/Domestic Partner of Record's coverage in order for you to cover them as Dependents under the Plan.

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

You should consider carefully whether it is advantageous to enroll your Spouse of Record/Domestic Partner of Record as a Dependent under the Plan if the coverage offered by his or her employer is as comprehensive as or better than the coverage offered on the Exchange. Whether the coverage your Spouse of Record/Domestic Partner of Record would purchase on the Exchange or your Spouse of Record's/Domestic Partner of Record's employer-sponsored coverage pays primary will depend on the coordination of benefits rules of those plans. Please refer to the coordination of benefits rules of your Spouse of Record's/Domestic Partner of Record's employer-sponsored coverage. You may choose to waive coverage for your Spouse of Record/Domestic Partner of Record under the Plan by declining to purchase coverage on the Exchange in order to save premium dollars. If you decline to purchase coverage on the Exchange, then no coordination of benefits will occur.

Dependent Child(ren)

A Dependent Child is generally not eligible to participate in this Plan. In general, a Dependent Child is eligible for this Plan only if the child is incapable of self-sustaining employment because of a physical or mental disability and is Eligible for Medicare (age 65 or older). To be eligible for coverage under the Plan, the child must meet the definition of "Dependent Child," satisfy the eligibility provisions for Dependents described in this Section 3.2 above (*e.g.*, be Eligible for Medicare, enrolled in a Medicare or a Medicare Advantage Plan, and enrolled in a plan on the Exchange), and not be excluded for reasons described in "Dependent Child(ren) Exclusions" below (*e.g.*, children over age 26 are excluded unless they are disabled prior to age 26). If the child is not eligible for this Plan, he or she may be eligible for coverage under one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program. Please contact the Retiree Service Center for more information. A "Dependent Child" is a child who must be:

- your birth or legally adopted child; or
- your Spouse of Record's or Domestic Partner of Record's natural or adopted child; or
- a child for whom you or your Spouse of Record/Domestic Partner of Record 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.

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

Dependent Child(ren) Exclusions

Your Dependent Child will not be eligible for coverage under this Plan:

- *Before becoming Eligible for Medicare*. A child must, in addition to meeting the requirements described in the preceding sections, be Eligible for Medicare (age 65 or older) to be eligible for coverage under this Plan. Children age 26 or older are not eligible for coverage under the Program, unless, prior to age 26, the child is incapable of self-sustaining employment because of a physical or mental disability and in addition to meeting the enrollment requirements described in *Section 4. Enrollment*, you submit proof at the time of enrollment that the child was covered as a dependent under his or her parent's medical plan immediately prior to enrolling in the Plan. 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 at enrollment. Once coverage is terminated, it cannot be reinstated. Contact the Retiree Service Center for more information; or
- *If your Dependent Child is covered as a Dependent under another Dow-sponsored or UCC-sponsored medical plan*. All eligible children in a family must be covered by the same parent. (Exceptions may be made as necessary in stepchild situations.)

The loss of coverage for your Dependent will occur on the date your Dependent becomes ineligible. For information about rights your child may have for continuation of coverage under the Program as provided by the federal COBRA law, see *Section 10.2 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 but otherwise meets the Plan's eligibility requirements (*e.g.*, is disabled and Eligible for Medicare (age 65 or older)) may still be eligible for coverage under the Program or The Dow Chemical Company Insured Health Program if the DCC Non-

Grandfathered Retiree (or other individual eligible for coverage under Section 3.1 of this SPD) has a "qualified medical child support order" for that child. A Qualified Medical Child Support Order ("QMCSO") is a court order that meets the Program's requirements to provide a child the right to be covered under one of the plans offered under the Program or under The Dow Chemical Company Insured Health Program. A child with a QMCSO may be eligible to receive coverage under one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program, if he or she does not satisfy the eligibility requirements of this Plan. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Program.

Typically, a divorce decree that orders the DCC Non-Grandfathered Retiree to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree (or a document signed by either the DCC Non-Grandfathered 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 DCC Non-Grandfathered Retiree 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 DCC Non-Grandfathered Retiree or custodial parent, the Program reserves the right to require the DCC Non-Grandfathered Retiree and/or custodial parent to obtain a court order to resolve the ambiguity.

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

3.3 Special Eligibility Rules If You or Your Dependents Are Eligible for Medicare

If you are a DCC Non-Grandfathered Retiree and you or some of your Dependents are Eligible for Medicare, the following rules apply to you and your Dependents:

Prior to Split Coverage

Before Dow transitions to split coverage (described below), if you *and all* of your Dependents are Eligible for Medicare and meet the eligibility requirements of Section 3.1 or Section 3.2, as applicable, you and your Dependents are eligible to participate in the Plan. If not all of you *or* your Dependents are Eligible for Medicare, you and your Dependents may *not* enroll in the Plan, but may enroll in any other plan offered under the Program or The Dow Chemical Company Insured Health Program for which you and your Dependents are eligible.

Split Coverage

When Dow transitions to split coverage (see below for effective dates), you and any Dependents will no longer be eligible for coverage under the other plans offered under the Program or The Dow Chemical Company Insured Health Program as soon as you or that Dependent becomes Eligible for Medicare (subject to the extension for those who enroll at Retirement, described below). Instead, you and any Dependents who are Eligible for Medicare and meet the eligibility requirements of Section 3.1 or Section 3.2, as applicable, are eligible for the Plan and to purchase coverage on the Exchange.

Dow will transition to split coverage as follows:

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

- If you or your Dependent enrolls in the Program before April 1, 2017, and becomes Eligible for Medicare before April 1, 2017, split coverage applies effective January 1, 2018.

If you are Eligible for Medicare, you must be enrolled in this Plan in order to enroll a Dependent in this Plan (if the Dependent is Eligible for Medicare) or in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program (if the Dependent is not Eligible for Medicare). If you are not Eligible for Medicare but one or more of your Dependents is Eligible for Medicare, you must be enrolled in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program to enroll your eligible Dependent(s) in this Plan.

Medicare Prescription Drug Coverage/Medicare Advantage Plan Exclusion

If you enroll in prescription drug coverage that is not purchased through the Exchange and that is provided under either a Medicare Advantage Plan or a Medicare prescription drug plan (Medicare Part D), you are ***NOT*** eligible for coverage under the Plan. You cannot be enrolled in **both** the Plan and a Medicare Advantage Plan or separate Medicare prescription drug coverage at the same time if either is purchased outside of the Exchange. Similarly, none of your Dependents may be enrolled in **both** the Program and a Medicare Advantage Plan or Medicare prescription drug coverage at the same time if either is purchased outside of the Exchange. In addition, neither you nor your Dependents may enroll in more than one plan offered on the Exchange that provides Medicare prescription drug coverage.

3.4 International Medical and Dental Plan Exclusion

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

If you are no longer eligible for the International Medical and Dental Plan as a retiree because you are a citizen of the United States who has returned from abroad to reside in the United States, you may be eligible for coverage under the Program.

3.5 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 25. Claims Procedures*.

Section 4. Enrollment

If you meet the eligibility requirements described in Section 3 above, you may enroll in the Plan. After Dow transitions to split coverage (as described above in *3.3 Special Eligibility Rules If You or Your Dependents Are Eligible for Medicare*):

- If you are Eligible for Medicare, you must be enrolled in the Plan in order to enroll a Dependent in this Plan (if the Dependent is Eligible for Medicare) or in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program (if the Dependent is not Eligible for Medicare).

- If you are not Eligible for Medicare, you must be enrolled in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program in order to enroll a Dependent in this Plan. See *3.2 Dependent Eligibility*, above.

4.1 Enrolling at Retirement

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

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

If you do not enroll yourself and/or your eligible Dependents in the Plan within 90 days after Retirement, you and/or they will not be covered. You will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 5. Mid-Year Election Changes* and *Split Coverage* under Section 3.3).

On or after April 1, 2017, if you seek to enroll in the Plan upon Retirement, you and your eligible Dependents may be enrolled in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program for up to two calendar months following the last day of the month in which you Retire (*i.e.*, the day you lose coverage under a Dow-sponsored medical plan for Employees), even though you or your Dependent(s) are Eligible for Medicare at that time. You or your Dependent(s) will be enrolled in the Plan as soon as the Plan Administrator determines that you or your Dependent(s) have enrolled in a plan purchased through the Exchange and have met all other eligibility and enrollment requirements. Your coverage under the other plan offered under the Program or The Dow Chemical Insured Health Program will end on the earlier of (1) the date of enrollment in the Plan or (2) the end of the second month following the last day of the month in which you Retire.

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

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

If you do not provide proof of Dependent eligibility within the timeframe required by the Plan Administrator, you will not be able to enroll the Dependent in the Plan until the next applicable enrollment period. If you are seeking to enroll a Dependent in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program (if the Dependent is not Eligible for Medicare), different rules may apply if you do not timely provide proof of Dependent eligibility. See the Summary Plan Description for the other plan.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 9. Fraud Against the Program*.

4.2 Annual Enrollment

Annual enrollment is typically held during the last quarter of the year and is handled electronically. Subject to the eligibility rules and to the rules described in *Section 4.4 Re-Enrolling After Waiving*

Coverage, below, you may enroll for coverage, switch plans, or waive coverage at this time. If you wish to add a Dependent – either a Spouse of Record/Domestic Partner of Record or an eligible child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll.

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

If you wish to add a Dependent, you must provide proof of Dependent eligibility no later than 90 days after the start of the applicable Plan Year (the **"90-Day Deadline"**). Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

If you do not provide proof of Dependent eligibility by the 90-Day Deadline, you will receive a notification (**"Notification of Termination"**) that your Dependent's coverage terminated as of the 90th day after the start of the Plan Year. You may provide proof of Dependent eligibility by no later than 30 days after the date of the Notification of Termination (the **"30-Day Deadline"**) to have your Dependent reinstated retroactive to the beginning of the Plan Year.

If you do not submit proof of Dependent eligibility by the 30-Day Deadline, *you will not be able to enroll the Dependent in the Plan until the next applicable enrollment period.* If you are seeking to enroll a Dependent in one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program (if the Dependent is not Eligible for Medicare), different rules may apply if you do not timely provide proof of Dependent eligibility. See the Summary Plan Description for the other plan.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 9. 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 *Section 10.2 COBRA Continuation Coverage* for more information about COBRA coverage.

Default Enrollment

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

4.3 Re-Enrolling After Waiving Coverage

If at any time on or after January 1, 2018, you waive coverage under the Plan and you subsequently would like to enroll for coverage under the Plan, you may do so at the times described in Section 4.2 Annual Enrollment or *Section 5. Mid-Year Election Changes*, provided that you may enroll in the Plan only if:

- You meet the eligibility requirements of both the Program and the Plan; and
- You submit proof that at the time of enrollment you either:
    - lost active employee medical coverage sponsored by another employer, including an employer of your Spouse/Domestic Partner; or

- lost subsidized retiree medical coverage sponsored by another former employer or a former employer of your Spouse/Domestic Partner because it was discontinued by the sponsoring employer.

4.4 Dual Dow, DCC, UCC, or ROH Coverage

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

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

Section 5. Mid-Year Election Changes

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

This Section 5. Mid-Year Election Changes describes the rules for making a mid-year election change to enrollment in the Program, including for special enrollment events or a "change in status," 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 the Plan pursuant to these mid-year election change rules is subject to the eligibility rules for the Plan. See *Section 3. Eligibility*, as well as rules that apply if you attempt to re-enroll after waiving coverage under the Plan. See *Section 4.4 Re-Enrolling After Waiving Coverage*.

You may generally change your enrollment in the Program or a Plan or change your level of participation (*e.g.*, the number of Dependents enrolled) only as follows:

- During annual enrollment, you may make any change to your participation in the Program, including enrolling or disenrolling in the Program, changing your Dependent (if not Eligible for Medicare) to a different Plan, or changing your level of Participation by adding or dropping Dependents.
- If you have a special enrollment event described in *Section 5.1 Special Enrollment Provisions* or another permissible change event described in *Section 5.4 Other Permissible Changes*, you may enroll, increase your level of participation, or change your Dependent (if not Eligible for Medicare) to a different Plan outside of annual enrollment.
- If you have a "change in status", you will be permitted to change, outside of annual enrollment, your or a Dependent's enrollment in the Program or a Plan or change your level of participation only to the extent that the change is consistent with the event.

5.1 Special Enrollment Provisions

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

- ***Loss of Other Medical Coverage***. If you decline enrollment in the Program for you or your Dependent(s) (including your Spouse of Record/Domestic Partner of Record) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependent(s) outside of the usual annual enrollment period if you or your Dependent 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 Program, you or your eligible Dependent must enroll in the Dow-sponsored coverage within 90 days after the other coverage ends. However, if you or your Dependent declined Dow-sponsored coverage because of other coverage provided through COBRA, you or your Dependent must wait until the annual enrollment period unless the entire period of coverage available under the COBRA coverage has been exhausted. An individual need not elect COBRA coverage under another health plan in order to use these special enrollment provisions.
- ***Marriage, Birth, or Adoption***. Subject to the eligibility rules in *Section 3.2 Dependent Eligibility*, if you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may receive coverage under the Program for yourself and your new Dependent if you enroll in the Program within 90 days after the Marriage, Domestic Partnership, birth, adoption, or placement for adoption.
- ***Loss of Medicaid or SCHIP***. If you or your Dependent either (i) loses coverage under Medicaid or a State Child Health Insurance Plan ("SCHIP"), or (ii) becomes eligible for premium assistance under the Program through Medicaid or SCHIP, you may receive coverage for yourself and your Dependent if you enroll within 90 days.

In order to enroll in the Program because of a special enrollment event described above, you must provide proof of the event in accordance with *Section 5.6 Documentation of Eligibility Required to Make Election Changes* and enroll by the deadline described in *Section 5.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 5.7 Deadline to Enroll for Mid-Year Changes*. Note: You or your Dependent may not be eligible for this Plan but may be eligible for one of the other plans under the Program or under The Dow Chemical Company Insured Health Program. Please refer to *Split Coverage* in Section 3.3 for more information.

5.2 Change in Status

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

- Divorce, annulment, or Termination of Domestic Partnership, or death of your Spouse of Record/Domestic Partner of Record.
- Birth, adoption or placement for adoption, or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- A change in the place of residence or work of you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- Your Dependent satisfies or ceases to satisfy the definition for "Dependent Child."

- Your Spouse of Record/Domestic Partner of Record or Dependent Child gains eligibility for coverage under his or her employer's health plan.

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

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

5.4 Other Permissible Changes

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

- ***Court Orders*** – You may change your election mid-year if a court order resulting from a divorce, annulment, or change in legal custody (including a Qualified Medical Child Support Order), requires a change in your medical plan election.
- ***Significant Cost or Coverage Changes*** – If your Spouse of Record/Domestic Partner of Record is covered by his or her employer's plan, which allows him or her to change his or her benefit plan election because of a significant change in cost or coverage under the employer's plan, such change in your Spouse of Record's/Domestic Partner of Record's election may allow you to change your Dow election. If your Spouse of Record's/Domestic Partner of Record's employer's enrollment period is different from Dow's, your Spouse of Record's/Domestic Partner of Record's election under his or her employer's plan may constitute a significant coverage change allowing you to change your Dow election. In each case, your new election must be on account of and correspond with the change under your Spouse of Record's/Domestic Partner of Record's employer plan.
- ***Special Enrollment Rights*** **–** You may enroll yourself and/or a Dependent in a Plan mid-year if you meet, and to the extent permitted by, the special enrollment requirements addressed in *Section 5.1 Special Enrollment Provisions.*

5.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated changes you are permitted to make. Any change is subject to meeting the Dependent eligibility rules and the eligibility rules for the relevant coverage option, as applicable. See also *Section 4.4 Re-Enrolling After Waiving Coverage*.

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll or you may increase your level of participation (*e.g.*, number of enrolled Dependents). You may change your Dependent (if not Eligible for Medicare) to a different plan under the Program or The Dow Chemical Company Insured Health Program.
Lose a Dependent • Divorce • Death • Dependent loses eligibility • Termination of Domestic Partnership	You may decrease your level of participation (*e.g.*, number of enrolled Dependents). You many not change a Dependent to a different plan under the Program or The Dow Chemical Company Insured Health Program.
Spouse of Record/Domestic Partner of Record loses medical coverage elsewhere	You may enroll, increase your level of participation (*e.g.*, number of enrolled Dependents), or change your Dependent (if not Eligible for Medicare) to a different plan under the Program or The Dow Chemical Company Insured Health Program.

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

In general, you are required to provide proof of eligibility to make a mid-year election change for yourself and/or a Dependent, and, if applicable, proof of Dependent eligibility by day 90 after the change in status or special enrollment event (the **"90-Day Deadline"**). If you do not provide such proof by the 90-Day Deadline, you will receive a notification (**"Notification"**) that coverage for anyone enrolling mid-year (*i.e.*, you and/or your Dependent) terminated as of the 90-Day Deadline. You may provide proof by no later than 30 days after the Notification (the **"30-Day Deadline"**) to have you and/or your Dependent reinstated retroactive to the first day that you and/or your Dependent were enrolled in the Plan.

If you do not submit such proof by the 30-Day Deadline

1. *You will not be able to enroll yourself and/or your Dependent in **the Plan** until the next applicable enrollment period.*

2. If you are already enrolled in the Plan and the mid-year change is to enroll a Dependent in another plan under the Program or The Chemical Company Insured Health Program, the following rules will apply to your Dependent's enrollment:

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

    b. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of eligibility to make a mid-year election change and/or proof of Dependent eligibility), the Program may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the plan for claims paid during the coverage period for your Dependent.

    c. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of eligibility by the date determined by the Plan Administrator, coverage will not be reinstated and will terminate as of the 90th day after the change in status or special enrollment event.

    d. If you pay 102% of the full cost of coverage and you provide acceptable proof of eligibility by the date determined by the Plan Administrator, your Dependent will be reinstated retroactive to the first day that your Dependent was enrolled in the plan and will remain covered under the plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 9. Fraud Against the Program*.

Dropping a Dependent

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

As explained in *Section 3.2 Dependent Eligibility*, if you or your Dependent is no longer eligible for coverage, you must update your enrollment information on the Dow Benefits web site or notify the Retiree Service Center; otherwise coverage may be dropped retroactively, and you may be required to reimburse the Plan for any subsidies it already paid.

Dropping a Domestic Partner

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

5.7 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the fall of each year), you must submit the required proof of eligibility and request enrollment within 90 days of the change in status or special enrollment event.

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 prior to the change in status or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date of the event.
  - If the Plan Administrator receives your enrollment request within 90 days after the change in status or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date the Plan Administrator receives your enrollment request.

Section 6. Health Reimbursement Account

6.1 Plan Benefit

If you and/or your Dependent enrolls in the Plan, Dow will establish a notional account called a Health Reimbursement Account ("Account"). An Account may be used to reimburse Eligible Premiums (described in Section 6.3, below). An enrolled individual may receive reimbursement for Eligible Premiums up to the balance of his or her Account. An Account does not accrue interest or other earnings of any kind.

The plans that you purchase through the Exchange are policies issued by insurance companies, are not sponsored by Dow, and are not part of the Plan, the Program or of any plan sponsored by Dow. Benefits under those plans are provided by the insurance company, not by Dow. All decisions under those plans will be made by the insurance company and not by Dow.

6.2 Annual Credits

Each Plan Year (the calendar year), if you and/or your Dependent are enrolled in a Medicare prescription drug plan (Medicare Part D) and/or Medicare supplement (Medigap) plan, or Medicare Advantage plan through the Exchange, Dow will apply a credit to an Account. The amount of the credit is determined based on the factors below:

DCC Deferred Retirees: A DCC Deferred Retiree and his or her covered Dependent(s) each receives the credit specified in the DCC Deferred Retiree's benefit agreement.

DCC Non-Grandfathered Retirees who are not DCC Deferred Retirees:

- If the DCC Non-Grandfathered Retiree was first eligible to Retire before January 1, 2016, the DCC Non-Grandfathered Retiree and his or her covered Dependent(s) each receives a credit of $2,020 for 2017. This credit may be adjusted annually for inflation but is capped at $2,400 per covered individual.
- If the DCC Non-Grandfathered Retiree was first eligible to Retire on or after January 1, 2016, the DCC Non-Grandfathered Retiree and his or her covered Dependent(s) each receives a credit of $2,000.

If you or a Dependent enroll in the Plan at any time outside of annual enrollment, the amount of your credit is prorated based on the number of full months remaining in the Plan Year after the effective date of your or the Dependent's enrollment, as applicable. For example, if you are eligible to participate in the Plan and you enroll in a qualifying plan through the Exchange on June 15, 2018, there will be six months remaining in the 2018 Plan Year when you become a Participant. You will receive a prorated credit in the

amount of 6/12 of the standard 2018 credit—*i.e.*, $1,000 if the applicable credit is $2,000. You will receive no credit for any time before an individual's enrollment in a plan offered through the Exchange was effective or after the individual's participation in the Plan terminates.

6.3 Eligible Premiums

Premiums for the following are Eligible Premiums that may be reimbursed from an Account:

- Medicare Part B
- Medicare supplement (Medigap) plan purchased through the Exchange
- Medicare prescription drug plan (Part D) purchased through the Exchange
- Medicare Advantage plans purchased through the Exchange

The following may ***not*** be reimbursed from an Account:

- Premiums for plans not purchased through the Exchange;
- Out-of-pocket costs for prescription and over-the-counter drugs;
- Out-of-pocket medical costs;
- Dental expenses;
- Vision expenses;
- Long-term care services;
- Other incidental costs;
- Life insurance;
- Other expenses that do not qualify for a medical expense deduction on your federal income taxes;
- Expenses incurred when you are not a Participant in the Plan;
- Expenses that are submitted after the claim deadline, which is December 31st of the year following the year in which the expense was incurred; or
- Expenses that are reimbursed under another plan.

Claim Deadlines

Claims for reimbursement from the Account must be submitted by December 31st of the year after the year for which the Eligible Premiums are paid. For example, claims for Eligible Premiums paid for coverage for 2017 must be submitted by December 31, 2018.

Interaction with Other Plans

Only Eligible Premiums that have not been and will not be reimbursed by any other source are eligible for reimbursement from an Account. You and/or your Dependent must first submit claims for Eligible Premiums to all other plans in which you participate before submitting the premium to this Plan for reimbursement.

More Information

For more information regarding whether a premium is reimbursable from an Account, contact Your Spending Account Service.

6.4 Account Balances at the End of the Plan Year

If you and/or your enrolled Dependent(s) do not use all of the amounts credited to your Account during a Plan Year, the unused balance will be carried over to the next year.

6.5 After an Individual Stops Participating in the Plan

When you and/or a Dependent cease to be a Participant in the Plan (*e.g.*, you cancel your Medicare supplement plan purchased through the Exchange), you will have until the end of the next year to request reimbursement of premiums from your Account incurred while you and/or the Dependent were a Participant in the Plan. For example, if you stop participating in the Plan on February 1, 2018, you will have until December 31, 2019, to submit reimbursement requests from your Account. Premiums incurred for coverage after an individual ceases to be a Participant will not be reimbursed.

If an individual does not re-enroll in the Plan, his or her Account will be forfeited. If you elect not to re-enroll in the Plan, you generally will not be eligible to re-enroll in a later year. See *Section 4.4 Re-Enrolling After Waiving Coverage* for more information.

When an individual dies, any balance remaining in his or her Account will be forfeited.

6.6 How the Plan Works with Medicare

Medicare is your and an eligible Dependent's primary source of medical and prescription drug benefits. The Plan is intended to supplement Medicare benefits by providing reimbursement through the Account for the costs of your Medicare Advantage or Medicare prescription drug and/or Medicare supplement plan premiums purchased through the Exchange.

The Plan does NOT provide creditable prescription drug coverage because an Account may not be used to reimburse prescription drug costs (though you may use your Account to pay premiums for prescription drug coverage purchased through the Exchange). Therefore, coverage under the Plan is considered Non-Creditable Coverage. You and/or your Dependent(s) may have to pay a higher premium (a penalty) if you and/or your Dependent(s) do not join a Medicare drug plan when you or your Dependent(s) first become eligible or when you or your Dependent(s) lose creditable prescription drug coverage. See Appendix B for an important notice about coordination of this Plan with Medicare.

Section 7. Survivor Benefits

7.1 Surviving Dependent of a Deceased DCC Employee

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

- If the deceased DCC Employee would have been a DCC Non-Grandfathered Retiree on his or her date of death, a Surviving Spouse/Domestic Partner will be eligible for medical coverage under the Plan as a DCC Non-Grandfathered Retiree, provided that the Surviving Spouse/Domestic Partner meets the eligibility requirements in *Section 3.2 Dependent Eligibility*.
- If the Surviving Spouse/Domestic Partner remarries, he or she cannot cover a new spouse or domestic partner.
- A Surviving Spouse/Domestic Partner does not need to be enrolled at the time of the DCC Employee's death to be eligible. However, depending on whether he or she is covered under another health plan, he or she may be restricted in which Dow plan he or she may enroll. The rules described in *Section 4.3 Re-Enrolling After Waiving Coverage* apply.

- A Surviving Spouse/Domestic Partner who is employed full time (or retired) and is eligible for employer-sponsored health coverage must be enrolled in that coverage in order to continue Dow coverage. If a Surviving Spouse/Domestic Partner is enrolled for Dow coverage, any surviving Dependent Child(ren) also may be covered as long as they meet eligibility requirements described in *Section 7.4 Surviving Children*. In order to be eligible for coverage, the surviving Dependent Child(ren) must be enrolled in any employer-sponsored coverage for which they are eligible. After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.
- If the surviving Dependent is less than age 65 at the time of the active DCC Employee's death, he or she may be eligible for coverage under one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program.

7.2 Surviving Dependent of a Deceased DCC Non-Grandfathered Retiree

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

If you are a Surviving Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree, you are eligible for medical coverage under the Program as a DCC Non-Grandfathered Retiree.

If you are a surviving Dependent Child of a DCC Non-Grandfathered Retiree, you are eligible for medical coverage under the Program as a Dependent Child of DCC Non-Grandfathered Retiree until you cease to be a Dependent Child (generally, until you turn age 26; note, however, that a child must meet the eligibility requirements described in *Section 3.2 Dependent Eligibility* to be eligible for coverage under this Plan, including being Eligible for Medicare); provided the Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program and you meet eligibility requirements described in *Section 7.4 Surviving Children*.

A surviving Dependent does not need to be enrolled at the time of the DCC Non-Grandfathered Retiree's death to be eligible. Depending on whether the Surviving Spouse of Record/Domestic Partner of Record is covered under another health plan at the time of the DCC Non-Grandfathered Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be restricted in which Dow Plan he or she may enroll.

If a Surviving Spouse of Record/Domestic Partner of Record is employed full time or is retired, and is eligible for employer-sponsored health coverage (including from a former employer), the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that coverage in order to obtain coverage under the Program. If a Surviving Spouse/Domestic Partner is enrolled for Dow coverage, any surviving Dependent Child(ren) also may be covered as long as they meet eligibility requirements. In order to be eligible for coverage, the surviving Dependent Child(ren) must be enrolled in any employer-sponsored coverage for which they are eligible.

To enroll in the Plan, the Surviving Spouse of Record/Domestic Partner of Record or surviving Dependent Child must meet the eligibility requirements of *Section 3. Eligibility*. If the Surviving Spouse of Record/Domestic Partner of Record or surviving Dependent Child is not Eligible for Medicare (age 65 or older), he or she may be eligible for coverage under one of the other plans offered under the Program or The Dow Chemical Company Insured Health Program. Contact the Retiree Service Center for more information.

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

Remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree from eligibility for coverage. 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 DCC Non-Grandfathered Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record may enroll for coverage only during annual enrollment or if there is a change in status.

7.4 Surviving Children

If a Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program, the surviving child(ren) of the DCC Non-Grandfathered Retiree, including a biological child *in utero*, may also be covered. Note, however, that a child must be Eligible for Medicare (age 65 or older) to be eligible for coverage under this Plan. The child must meet the Dependent eligibility requirements. If a Surviving Spouse of Record/Domestic Partner of Record works full time or is retired, he or she must enroll the surviving child(ren) in employer-sponsored health coverage for which they are eligible (including from a former employer).

If there is no Surviving Spouse 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 under the Program 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"). *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.*

After December 31, 2017, no one will be an eligible surviving Dependent Child of a DCC Employee.

Section 8. Notices

The notice below is prescribed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

8.1 Information Exchanged by the Program's Business Associates

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

Section 9. 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, the Program and/or Dow may pursue civil and/or criminal action against you, or take other legal action. If you or your Dependent(s) are terminated from eligibility under any benefit plan sponsored by Dow or a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 10. Ending Coverage

10.1 When Coverage Ends

A Participant's coverage ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Participant elects not to participate for the Plan Year
- The Participant's death
- Termination of the Plan or Program
- Failure to 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 Retiree Service Center within 90 days of the loss of eligibility. The loss of coverage for your Dependent will occur on the date your Dependent becomes ineligible.

If you cease to be eligible to participate in the Program and elect COBRA continuation coverage, your coverage terminates at the times described in *How Is COBRA Coverage Provided?*, below. Generally, your Dependent's coverage under the Plan will terminate when your coverage terminates unless your Dependent:

- elects COBRA (see *Section 10.2 COBRA Continuation Coverage*); or
- is eligible to participate after your death in accordance with *Section 7. Survivor Benefits*.

10.2 COBRA Continuation Coverage

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

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

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

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

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

North America Health and Insurance Plans Leader
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
(800) 344-0661

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

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

What Is COBRA Continuation Coverage?

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

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

1. Your spouse dies;
2. Your spouse enrolls in Medicare (Part A, Part B, or both); or
3. You become divorced or legally separated from your spouse.

As explained under *Section 10.2 COBRA Continuation Coverage*, although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners of Record with comparable protection to Spouses of Record for the qualifying events described above.

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

1. The parent-DCC Non-Grandfathered Retiree dies;
2. The parent-DCC Non-Grandfathered Retiree enrolls in Medicare (Part A, Part B, or both);
3. The parents become divorced or legally separated; or
4. The child stops being eligible for coverage under the Program as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in

you losing coverage, you are a qualified beneficiary with respect to the bankruptcy. Your Spouse of Record, Surviving Spouse of Record, and Dependent Child(ren) will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When Is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is your death, commencement of a proceeding in bankruptcy, or your enrollment in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of any of these events.

IMPORTANT: *You* Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation or a Dependent Child's losing eligibility for coverage as a Dependent Child), **you must notify the Plan Administrator within 60 days after the qualifying event occurs**. Except for divorce, you may provide this notice by calling the Plan Administrator at the telephone number provided above. In addition, you must complete and submit the forms described below within the time required. Written notice is required if the qualifying event is divorce. If you are providing written notice, you must send this notice to the Plan Administrator at the address above. In addition, if the qualifying event is divorce, you must provide the following to the Plan Administrator within 60 days of the qualifying event:

- A copy of the page of the divorce decree that specifies the names of the parties of the divorce
- A copy of the page of the divorce decree that shows the judge's signature and the effective date of the divorce
- Former Spouse's mailing address
- Former Spouse's Social Security number

If your Domestic Partnership ends, you must provide the Plan Administrator with a valid "Termination of Domestic Partner Relationship" form within 60 days of the end of the Domestic Partnership.

If the qualifying event is a Dependent Child's loss of eligibility for coverage under a Plan, you must call 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 of Record/Domestic Partner of Record or Dependent Child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

How Is COBRA Coverage Provided?

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

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

elect continuation coverage within this 60-day election period, the qualified beneficiary WILL LOSE HIS OR HER RIGHT TO ELECT CONTINUATION COVERAGE.

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

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

Continuation coverage terminates before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees or retirees. Continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

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

How Much Does COBRA Continuation Coverage Cost?

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

First Payment of Continuation Coverage

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

Your first payment must cover the cost of continuation coverage from the time your coverage under the Program would have otherwise terminated 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 DCC Non-Grandfathered 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 Program, 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 Program, 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 11. Subrogation

As used in this Section 11, these terms have the following meaning:

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

11.1 The Program's Entitlement to Reimbursement

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

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

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

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

First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person acknowledges that the Program's recovery rights are a first priority claim against all Third Parties and are to be paid to the Program before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Program is entitled to full reimbursement on a first-dollar

basis from any Responsible Party Payments, ***even if such payment to the Program will result in a recovery to the Covered Person that is insufficient to make him or her whole*** (*i.e.*, the "make whole" doctrine will not apply).

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

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

11.2 Your Responsibilities

The Covered Person is required to fully cooperate with the Program's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Program, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Program may reasonably request. The rights described in this Section 11 are assigned to the Program without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Program an assignment and other instruments that may be used to facilitate securing the rights of the Program. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

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

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

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

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

11.3 Jurisdiction

For purposes of this Section 11, by accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Program may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Section 12. Your Legal Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Program, including collective bargaining agreements (if applicable), the Plan Document, and the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.
- Continue health care coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents must pay for such coverage. For more information, see *Section 10.2 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 17. 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 Exchange. For the contact information for the Plan Administrator and for the Exchange, 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 13. Plan Administrator's Discretion

The Plan Administrators are the Global Benefits Director and the North America Health and Insurance Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 25. Claims Procedures*.

Section 14. Plan Document

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

Section 15. 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 16. Dow's Right to Terminate or Amend the Program

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

If the Company terminates a plan under the Program, 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 17. Litigation and Class Action Lawsuits

17.1 Litigation

If you wish to file a lawsuit against the Program or the Plan (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures described in *Section 25. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA. (A lawsuit against the Plan is considered a lawsuit against the Program of which the Plan is a part, for purposes of this SPD.)

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

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

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

A Claim for Plan Benefits or an appeal of a complete or partial denial of a Claim, as described in the claims and appeals sections, generally falls under (1) above. Please note, however, that if you have a timely Claim pending before the Initial Claims Reviewer or a timely appeal pending before the Appeals Administrator when the Applicable Limitations Period would otherwise expire, the Applicable

Limitations Period will be extended to the date that is 180 calendar days after the Appeals Administrator renders its final decision.

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

17.2 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 18. 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 19. 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 DCC Non-Grandfathered 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 DCC Non-Grandfathered Retiree, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its, his or her Advisors with respect to whom a privilege applies, unless mandated by a court order.

Section 20. 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 21. 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 22. Funding

Benefits are paid from the Company's general assets.

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

Section 23. Uncashed Checks

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

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

Section 24. Payment of Unauthorized Benefits

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

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

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

Section 25. Claims Procedures

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

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

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 25.4 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

25.1 Deadline to File a Claim

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

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

The Program has more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you 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 Your Spending Account Service.
- *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 25. Claims Procedures* (or the Claims Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *Section 17.1 Litigation* for the deadline for filing a lawsuit.

25.3 An Authorized Representative May Act on Your Behalf

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

25.4 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

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

- The name of the DCC Non-Grandfathered Retiree and the name of the person (DCC Non-Grandfathered 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 Retiree Medical Care Program); and
- If the eligibility determination is being requested for the DCC Non-Grandfathered Retiree's dependent:
  - a description of the relationship of the dependent to the DCC Non-Grandfathered Retiree (*e.g.*, Spouse/Domestic Partner of Record, Dependent Child, etc.);
  - documentation of such relationship (*e.g.*, marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility 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 Retiree Medical Care 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 DCC Non-Grandfathered Retiree and the name of the person (DCC Non-Grandfathered Retiree, Dependent, Survivor, as applicable) who is appealing the Administrator's decision;
- The name of the Plan (The Dow Chemical Company Retiree Medical Care 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 Retiree Medical Care Program (Claim for Eligibility Determination)

You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You also may request that the Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator

in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

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

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

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

Section 26. Tax Consequences of Coverage and Benefits

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

Section 27. No Assignment of Benefits

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

Section 28. Definitions of Terms

The following are some of the defined terms of the Program. A copy of the Plan Document is available upon request of the Plan Administrator at the contact information provided in *Section 1. ERISA Information*.

Appeals Administrator
The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is Your Spending Account Service. 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.

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

Claim for an Eligibility Determination
A Claim requesting a determination as to whether a claimant is eligible to be a Participant under the Plan or the Program or as to the amount of the contribution to the HRA.

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.

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

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

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

1. If the Employee's employment with DCC terminated prior to January 1, 2006 (referred to as the "pre-January 1, 2006 termination date"), and the Employee was subsequently re-hired by DCC before October 1, 2016, and participated in the pre-2006 formula of Appendix J of the Dow Employees' Pension Plan (formerly the Dow Corning Corporation Employees' Retirement Plan) and no other formula under the Dow Employees' Pension Plan after the Employee's re-hire date, the Employee's first hire-date will be recognized by the Program.
2. If, as of the Employee's pre-January 1, 2006 termination date, the Employee was eligible for coverage under the DCC medical plan for retirees in effect on the date of the Employee's pre-January 1, 2006 termination date, the Employee's first hire-date will be recognized by the Program.

3. If an Employee's date of re-hire with any Dow Entity is on or after October 1, 2016, and the Employee's first hire-date is not recognized under clauses (1) or (2) above, the Employee is not a DCC Employee.

DCC Grandfathered Retiree

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

DCC LTD Participant

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

DCC LTD Plan

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

DCC Non-Grandfathered Retiree

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

DCC Retiree

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

DCC Service

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

Dependent

A DCC Non-Grandfathered Retiree's Spouse of Record, Domestic Partner of Record, or Dependent Child(ren); or a child to whom a Qualified Medical Child Support Order applies.

Dependent Child

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

- Your birth or legally adopted child; or
- Your Spouse of Record's or Domestic Partner of Record's natural or adopted child; or
- A child for whom you or your Spouse of Record/Domestic Partner of Record 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 meet the eligibility requirements described in *Section 3.2 Dependent Eligibility* and not be excluded for one of the reasons described in *Dependent Child(ren) Exclusions* under Section 3.2 of this SPD.

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

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 DCC Non-Grandfathered Retiree, a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.)

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

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.

Dow Entity

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

Dow Medicare Advantage Plan

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

Eligible Premiums

Premiums for coverage identified in *Section 6.3 Eligible Premiums* that may be reimbursed from an Account.

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).

Exchange
The Aon Retiree Health Exchange.

HIPAA
The Health Insurance Portability and Accountability Act.

HMO
Health Maintenance Organization.

Initial Claims Reviewer
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is Your Spending Account Service. 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.

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

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

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

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

1. If an Employee was a participant of a plan of The Dow Chemical Company Medical Care Program before November 1, 1993, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a Dow Medical Plan before November 1, 1993, then such common law Spouse is deemed under the Program to be Married to the Employee;
2. Effective January 1, 1996, the Program recognizes a marriage that meets the requirements of Texas Family Code Annotated section 2.402; and

3. Effective January 1, 2002, common law Spouses of UCC employees and former UCC employees who were covered under a UCC medical plan at any time between February 5, 2001, and December 31, 2001, as "spouses" of UCC employees will be deemed to be "Married" for purposes of the Program.

Medicare

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

Medicare Advantage Plan

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

"Medicare-eligible" or "Eligible for Medicare"

A person who is eligible for Medicare because he or she meets the Medicare age eligibility requirements (currently, age 65). For example if a DCC Non-Grandfathered 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 DCC Non-Grandfathered Retiree is not yet old enough to meet the Medicare age eligibility requirement, then such DCC Non-Grandfathered Retiree does not become eligible for the Plan until he or she meets the Medicare age eligibility requirement.

Medicare Part D

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

Medicare prescription drug plan

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

Participant

A DCC Non-Grandfathered Retiree, Dependent, or other individual who meets the eligibility criteria of the Program, elects to participate in the Program, and remains eligible for benefits under the Program.

Participating Employer

The Company or one of its subsidiaries or affiliates that has been authorized by the Company to participate in the Program. "Participating Employers" and "Dow" have the same meaning and are used interchangeably. 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 Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees, which is one of several plans that are part of the Program.

Plan Administrator

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

Plan Document
The plan document for the Program, which is part of ERISA Plan #501. The summary plan descriptions for the plans offered under the Program are integral parts of the Plan Document.

Program
The Dow Chemical Company Retiree Medical Care 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*.

"Retire" or "Retirement"
"Retire" or "Retirement" means when a DCC Employee becomes a DCC Non-Grandfathered Retiree.

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

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

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

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

Spouse
A person who is Married to a DCC Non-Grandfathered Retiree. See the definition of Marriage for further details. 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 DCC Non-Grandfathered Retiree, the person who was Married to the former Employee on his or her last day on the payroll, and continues to be Married to the former Employee.

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

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

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 Program's Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees applicable to Participants, including its appendices. This SPD is an integral part of the Plan Document.

Surviving Spouse/Domestic Partner
The widowed Spouse/Domestic Partner of a DCC Employee who was eligible to participate in The Dow Chemical Company Medical Care Program at the time of death of the Employee or is otherwise eligible as provided in *Section 7. Survivor Benefits*.

Surviving Spouse of Record/Domestic Partner of Record
The widowed Dependent Spouse of Record/Domestic Partner of Record of a DCC Non-Grandfathered Retiree who participated in the Program, if such Spouse of Record/Domestic Partner of Record was an eligible Dependent at the time of the death of such DCC Non-Grandfathered Retiree or is otherwise eligible as provided in *Section 7. Survivor Benefits*.

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.

Section 29. For More Information

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

IMPORTANT NOTE

This booklet is the Summary Plan Description ("SPD") for the Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees offered under The Dow Chemical Company Retiree Medical Care 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 (and any underlying 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. Notice of Privacy Practices

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

Effective Date of Notice: January 1, 2017

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

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

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

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

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

B.1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

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

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

plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, The Dow Chemical Company Dental Assistance Program may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

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

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

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

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

Uses and Disclosures that Require Your Written Authorization

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

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

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

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

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

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

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

- To a business associate (e.g., a contractor) retained to perform services on behalf of the Plan when the business associate has agreed to safeguard your PHI.
- When required by law.
- When permitted for purposes of public health activities, included when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public

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

authorities if there exists a reasonable belief that you may be the victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

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

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

Prohibited Uses and Disclosures

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

B.2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

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

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

specify a reasonable alternative address or method of contract.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Requests to restrict uses and disclosures of your PHI should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; North America Benefits, P.O. Box 2169, Midland, MI 48641.

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

Right to Inspect and Copy PHI

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

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

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

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

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

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

Right to Request Amendment of PHI

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

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

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

Right to Receive an Accounting of PHI Disclosures

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

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

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

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

Right to Receive a Paper Copy of This Notice Upon Request

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

A Note About Personal Representatives

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

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

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

B.3. The Plan's Duties

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

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

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

Minimum Necessary Standard

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

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

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

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

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

Whom to Contact at the Plan for More Information

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

B.4. CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* parts 160 and 164. This notice attempts to summarize the regulations and set forth the Plan's legal duties, privacy practices, policies and procedures regarding your PHI. The regulations will supersede any discrepancy between the information in this notice and the regulations.

APPENDIX B. Important Notice of Non-Creditable Coverage

Applicable to Plan Year 2017

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Dow Chemical Company ("Dow") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Dow has determined that the prescription drug coverage offered by the Health Reimbursement Arrangement for DCC Non-Grandfathered Retirees (the "Plan") is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage under the Plan is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible. *This notice addresses only your coverage under the HRA under the Plan. It does not apply to, or make any statements, regarding any prescription drug coverage that you may have purchased through the Aon Retiree Health Exchange (the "Exchange"), as a condition of participating in the Plan.***
3. **You can keep your current coverage under the Plan. However, because your coverage under the Plan is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.**

When Can You Join A Medicare Drug Plan?

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

However, if you decide to drop your current coverage with Dow, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan. (Note, however, that you may both enroll in the Plan and purchase a plan on the Exchange that provides creditable coverage.)

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

Since the coverage under the Plan is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current Dow coverage will not be affected. You must be eligible for Medicare Part D to be eligible for the Plan. You can keep coverage under the Plan if you elect Part D, and the Plan will coordinate with Part D coverage. If you are eligible for this Plan, you may enroll in Part D coverage by purchasing a plan on the Exchange or through a separate provider.

If you do decide to join a Medicare drug plan and drop your current Dow coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

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

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

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

Date:	Spring 2017
Name of Entity/Sender:	The Dow Chemical Company
Contact--Position/Office:	North America Benefits
Address:	P.O. Box 2169 Midland, MI 48641
Phone Number:	(800)-344-0661

APPENDIX C. CHIP Premium Assistance Notice

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

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

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

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

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

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

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

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

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

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

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