DOW CORNING CORPORATION
HEALTH AND WELFARE BENEFITS PLAN
FOR RETIREES AND INACTIVE EMPLOYEES

Plan No. 507

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

Restated as of January 1, 2015

Dow Corning Corporation
Legal Department
P.O. Box 994
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NOTICE OF GRANDFATHERED STATUS

We believe that the Blue Cross Blue Shield of Michigan CDHP/HSA option offered under the Dow Corning Corporation Health and Welfare Benefits Plan For Retirees and Inactive Employees is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that this option may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, a grandfathered health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

The Blue Cross Blue Shield of Michigan PPO option is not a grandfathered health plan, and therefore this health plan option will comply with all consumer protections required by the Affordable Care Act.

Questions regarding which provisions apply and which provisions do not apply to a grandfathered or non-grandfathered health plan should be directed to the HR Service Center. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

INTRODUCTION

Dow Corning Corporation (the "**Company**") sponsors the Dow Corning Corporation Health and Welfare Benefits Plan For Retirees and Inactive Employees (the "**Plan**") for eligible Former or Inactive Employees of the Company and their families. Any affiliates and subsidiaries of Dow Corning Corporation that are approved by Dow Corning Corporation's Board of Directors to participate in the Plan and that have adopted the Plan are also included in the term "Company" and are listed on the Participating Affiliates Chart at the end of this document.

If you are an eligible Former Employee ("**Retiree**") or Inactive Employee, the Plan provides you with coverage under various welfare Benefit Plans that are components of this Plan. The Benefit Plans that may be available to you, depending on whether you are a Retiree or an Inactive Employee, are:

- A "**Medical and Prescription Drug Plan**" that provides comprehensive major medical, hospitalization, and prescription drug benefits;
- A "**Dental Plan**" that provides benefits to pay for maintenance and treatment services for teeth and gums (available to Retirees only until age 65 and for Inactive Employees as set forth in the booklet provided by the Claims Administrator);
- A "**Long-Term Disability Plan** (the "**LTD Plan**") that offers income replacement benefits for a period of time if you are disabled (available only to Inactive Employees as a continuation of the Long-Term Disability Plan offered under the Dow Corning Corporation Health and Welfare Benefits Plan For Active Employees); and
- A "Life Insurance Plan" that provides the following types of benefits, depending on your status:
    - For Retirees under age 65, Basic Life, AD&D, Optional Life and Dependent Life insurance coverage;
    - For Retirees age 65 and over, Basic Life insurance coverage; and
    - For Inactive Employees, Basic and Optional Life Insurance coverage.

Some of the benefits are insured, which means the Company pays premiums to insurance companies that then pay for the benefits under insurance policies or contracts. Other Benefit Plans are Self-funded. "**Self-funded**" means the benefits are paid from the Company's general assets and are not provided through an insurance contract. The Benefit Plan Information Chart at the end of this document indicates each Benefit Plan's type of funding.

For each insured Benefit Plan there is an insurance contract or policy that, together with this document, serves as the official Plan document for that Benefit Plan. The insurer also prepares one or more booklets, summaries, and/or certificates that describe the benefits available ("**Booklets**"). Those Booklets, together with this document, are the Summary Plan Description ("**SPD**") for the insured Benefit Plans. If a conflict arises

between the terms of this document, the Booklet, and the insurance policy or contract for a Benefit Plan, the terms of the insurance policy or contract will control.

You may also receive booklets and/or summaries from the third party administrators describing your benefits under one or more of the Self-funded Benefit Plans ("**Booklets**"). This document, along with those Booklets and/or summaries, serve as the Plan document and SPD for the Self-funded Benefit Plans.

This document and the accompanying Benefit Plan Booklets describe the provisions of the Plan as of January 1, 2015. The provisions of this Plan apply uniformly to all Participants. Please read these documents carefully and keep them with your personal records for future reference. Throughout this document, capitalized words have specific meanings and are defined terms. Where a term is defined, it also appears in bold print and in quotes. For your convenience, an Index of Defined Terms appears at the end of this SPD with page references to each defined term. If you have any questions about a Benefit Plan or the Plan in general, please call the **HR Service Center** at (989) 496-HRSC (4772) in Midland, or (800) 440-0772 outside the Midland exchange.

OBTAINING AND CHANGING COVERAGES

ELIGIBILITY

Former Employee Eligibility

If you are a former Employee of the Company who terminated active employment, you are eligible to participate in this Plan as a "**Former Employee**" if at the time of your termination you met each of the eligibility criteria.

Former employees whose hire date is before January 1, 2006: If your employment with the Company began before January 1, 2006, you must meet the following eligibility criteria:

- You were eligible for the Company's Medical and Prescription Drug Plan for Active Employees;
- You had at least 10 years of Company "**Credited Service**" (as defined in the Employee Retirement Plan); and
- You were at least age 50 when you terminated active employment with the Company.

Former employees whose hire date is on or after January 1, 2006: If your employment with the Company began on or after January 1, 2006, you must meet the following eligibility criteria:

- You were eligible for the Company's Medical and Prescription Drug Plan for Active Employees;
- You had at least 10 years of Company "**Credited Service**" (as defined in the Employee Retirement Plan); and

- You were at least age 55 when you terminated active employment with the Company.

You will also be eligible to participate in this Plan as a Former Employee if you elected coverage under this Plan as part of an early retirement or special separation package program offered from time to time by the Company. If this situation applies to you, the terms of your participation in this Plan are set forth in the document describing such programs, which are incorporated by reference as part of this Plan.

Inactive Employee Eligibility

If you are an Employee of the Company who has been placed on inactive status and are receiving benefits under the Long-Term Disability Plan ("**Inactive Employee**"), you and your spouse and children are eligible to participate in the Plan. Your coverage under this Plan will begin on the first day that your long-term disability benefits commence and will continue for as long as you remain in inactive status or until you reach age 65. If you continue to participate until age 65, at age 65 you will continue to participate as an eligible Former Employee.

If you are under age 65 and the Long-Term Disability claims administrator determines that you are no longer disabled, the Company will reclassify your employment status, at which time you will no longer qualify as an Inactive Employee and your participation in this Plan will end. If it is later determined that you are still entitled to Long-Term Disability benefits, the Company will restore your inactive status once you provide notice of the determination and you will once again be able to participate in this Plan on a go-forward basis.

Dependent Eligibility

Certain members of your family, called "Eligible Dependents," may also be eligible for coverage under the Plan. The HR Service Center may require you to periodically show proof that the Eligible Dependent criteria are met. You must notify the HR Service Center on or before the 60th day following the date of any status change that would result in a family member no longer being an Eligible Dependent (for example, your spouse in the event of a divorce). The Plan has a right to request proof of dependent status at the time an individual is initially added to the Plan, and periodically thereafter. The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (*Refer to Overpayments*).

An "**Eligible Dependent**" is:

- Your spouse, to whom you are legally married, provided that he or she was eligible to participate in the Dow Corning Health and Welfare Plan (for Active Employees) before the date you terminate active employment with the Company ("**Spouse**");
- Your eligible Domestic Partner of the same or opposite sex provided that he or she was eligible to participate in the Dow Corning Health and Welfare Plan (for Active Employees) before the date you terminate active employment with the Company. Specific eligibility criteria (described in more detail beginning at page 5) must be met and HR approval is required prior to enrollment;

- Your Child who has not reached his/her 26th birthday. For the Medical and Prescription Drug Plan and the Dental Plan, this shall mean your Child regardless of student or marital status or where he/she resides;
- Your Child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support Order ("QMCSO"); and
- Your unmarried Child who, before age 26, is totally disabled by a medically determined physical or mental condition that prevents him or her from being self-supporting and who is dependent on you for support and care. (*You must submit your written application for disabled dependent coverage to the HR Service Center before your Child turns 26 years old so that the Plan can confirm your Child's disabled status. The Plan reserves the right to periodically require medical certification satisfactory to the Plan of your Child's total disability.)*

Common-law spouses are not eligible for coverage under this Plan.

"**Child**" includes your natural child, step-child, legally adopted child, child placed with you in anticipation of the child being adopted by you, or child by virtue of legal guardianship. Child also includes your grandchild, if the parent of the grandchild is also your eligible dependent or if the grandchild is under your legal guardianship. Child also includes your Child who is determined to be an alternate recipient under a QMCSO. But Child does not include a child who is born, adopted or placed with you for adoption more than nine months after the date you terminate active employment.

Your Child will be eligible for coverage even if the Child is born out of wedlock, is not claimed by you as a dependent for federal income tax purposes, does not reside with you, or is married. This Plan allows your family members to be covered under this Plan, even if they may not be "qualified children" or "qualified relatives" under Code Section 152, and, thus, could not be declared as a dependent on your federal income tax returns.

Special Rule Regarding Double Eligibility

Your Spouse, Domestic Partner or Child cannot be Eligible Dependents if they have coverage under the Dow Corning Corporation Plan for Active Employees. Also, if you and your Spouse or Domestic Partner are both covered by plans sponsored by the Company as current or former Company employees, your Child cannot be an Eligible Dependent of both of you. In this case, you and your Spouse or Domestic Partner must decide which one of you will enroll the Child as an Eligible Dependent.

Special Rules Regarding Eligibility of Spouses and Domestic Partners

Your Spouse or Domestic Partner will not be eligible for dependent coverage under the Plan if he or she is:

- Enrolled as an employee under a Dow Corning affiliated company plan;
- Serving in the armed forces of any country; or

- Eligible for coverage as an employee or retiree under another company's plan, but not enrolled for personal coverage in the Plan, unless your Spouse/Domestic Partner works an annual average of less than 17.5 hours per week.

Working Spouses/Domestic Partners

If your Spouse/Domestic Partner is an employee of another company, he or she will be eligible for primary Medical and Prescription Drug Plan and/or Dental Plan coverage through this Plan if:

- He or she works less than 17.5 hours per week, regardless of whether your Spouse/Domestic Partner's employer subsidizes medical or dental coverage; or
- He or she works 17.5 or more hours weekly, but is not currently eligible for an employer-subsidized plan.

If your Spouse/Domestic Partner's employer offers a financial incentive to employees who do not elect coverage through that company's benefit plan, this is deemed to be a benefit subsidy. Your Spouse/Domestic Partner must enroll for primary coverage under that plan. He or she may, however, be enrolled for secondary coverage under this Plan.

"**Domestic Partner**" is a person of the same or opposite sex who lives with you in a long-term relationship of 12 months or more, with an exclusive mutual commitment similar to that of marriage. You will need to register your Domestic Partner with the Company by submitting an Affidavit of Domestic Partnership Form. If your domestic partner qualifies as your dependent under Section 105(b) of the Federal Tax Code, you will also need to submit a Declaration of Tax Status to the HR Service Center. You and your Domestic Partner must also satisfy the following:

- Reside at the same permanent residence for 12 months or more.
- Have resided in the same household for at least one year and have proven shared residency by providing evidence of the same address for 12 months or more.
- Are each other's sole domestic partner and intend to remain so indefinitely.
- Are both at least 18 years of age and mentally competent to consent to a contract.
- Must be financially interdependent for a period of at least one year and prove such interdependence by providing to the HR Service Center at least two of the following:
    - Evidence of a joint bank account;
    - Proof of joint lease/ownership of mutual residence;
    - Joint billing statements for residential utilities (gas, electric, telephone, etc.);
    - Joint insurance documents (property, life, automobile);
    - Joint credit card accounts;

- Joint loan agreements; or
- Joint automobile ownership.

- Are not related by blood in a manner that would bar legal marriage.
- Are not currently married to or legally separated from anyone else nor have you had another domestic partner within twelve months prior to designating each other as domestic partners.

If you and your Domestic Partner dissolve your Domestic Partnership, you must file a Declaration of Termination of Domestic Partnership Form with the HR Service Center, and you must wait at least twelve months to add another Domestic Partner. Domestic Partners are ***not*** entitled to COBRA Continuation Coverage.

Domestic Partner's Dependents
You may also cover your Company-approved Domestic Partner's children who meet the definition of "Child" under this Plan.

Imputed Income
To the extent that you are entitled to a premium subsidy, the value of the coverage provided under the Plan to your Domestic Partner or your Domestic Partner's dependents will be taxable income to you, unless your Domestic Partner and/or Domestic Partner's dependents meet the requirements for being your dependent under section 105(b) of the Federal Tax Code.

Surviving Dependent Benefits
If you die, your Spouse or Domestic Partner can continue to be covered under the Medical and Prescription Drug Plan offered through this Plan, even if he or she remarries. However, a Surviving Spouse or Domestic Partner may not add a new spouse or domestic partner, and may only add a new dependent child within nine months following your death. Coverage for your dependents may also continue, as long as they are eligible according to the guidelines that apply to dependents.

PARTICIPATION

To start participating in the Plan, you need to fill out and submit your benefit election forms according to the instructions in your enrollment materials. You will be provided with instructions upon your termination of active employment and periodically thereafter. You elect the Benefit Plans in which you wish to participate. Only you, as a Retiree or Inactive Employee, may make Benefit Plan elections. If you have properly enrolled in the Plan, you are a "**Participant.**"

An Eligible Dependent who is properly enrolled in a Benefit Plan is a "**Covered Dependent.**"

Newly acquired Eligible Dependents, for example, a new spouse or a newborn child, must be enrolled on or before the 60th day following the date of the event by which they become your Eligible Dependent. If not enrolled by the 60th day, they cannot be enrolled until the next Open or Special Enrollment Period or until you experience a Qualifying Life Event. Only those Children born within nine months of

your retirement/termination of active employment are eligible for coverage under the Plan.

Waiving Coverage as the Spouse of Another Dow Corning Employee
If you and your Spouse or Domestic Partner are both employees of the Company, you may enroll separately in your own policy or you may choose to waive your individual plan and be covered as a dependent under your Spouse or Domestic Partner's plan. If you choose to be covered as a dependent, however, you will not receive excess cash. Employees and/or their dependents cannot be enrolled twice under each other's policy.

Initial Enrollment Period
As a new Retiree or Inactive Employee, you will participate in the Benefit Plans on the first day of your retirement/termination of active employment. You will be automatically enrolled in plan options that correspond to the coverage you had under the Dow Corning Corporation Health and Welfare Benefits Plan For Active Employees and will have 60 days to make any changes in your election ("**Initial Enrollment Period**"). If you would like to have your contributions automatically deducted from your pension check, you must sign an authorization form before such deductions can begin.

Your election will be effective from the date you begin participating in the Plan. Elections during your Initial Enrollment Period are irrevocable until the next Open Enrollment Period unless you are eligible to enroll during a Special Enrollment Period or you experience a Qualifying Life Event.

If you leave this Plan because you have been rehired by Dow Corning and as a result are once again covered under the Dow Corning Health and Welfare Benefits Plan For Active Employees, you may reenroll in this Plan within the first 60 calendar days of the date you stop participating in the Dow Corning Health and Welfare Benefits Plan For Active Employees. If you leave this Plan for any other reason, you will not be eligible to re-enroll until the next open enrollment period unless you experience a Qualifying Life Event or are entitled to a Special Enrollment Period.

Open Enrollment Period
Each year the Company establishes an "**Open Enrollment Period**," which is usually toward the end of the Plan Year. During the Open Enrollment Period, you can make new benefit choices and elections for the upcoming Plan Year.

To change your benefit elections under the Plan or enroll for the first time during an Open Enrollment Period, if you failed to do so during your Initial Enrollment Period or during prior Open Enrollment Periods, you must complete your benefit election process before the Open Enrollment Period ends. The "**Period of Coverage**" is a 12-month period, beginning on the first day of the Plan Year. Therefore, the choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year, and once the Plan Year has started, your choices are irrevocable for that Period of Coverage, and will remain in effect without any changes permitted through the remainder of the Plan Year, unless you experience a Qualifying Life Event or are entitled to a Special Enrollment Period.

Special Enrollment Period

A "**Special Enrollment Period**" is a period of enrollment other than the annual Open Enrollment Period or an enrollment period for newly eligible Retirees or Inactive Employees during which you may elect to enroll in the Medical and Prescription Drug Plan and Dental Plan. You and your Eligible Dependents may enroll during a Special Enrollment Period in the following circumstances:

Enrollment Of Newly Eligible Child

If you gain a new Child as a result of birth, adoption, or placement for adoption, the following individuals may be enrolled in the Plan if they are not currently enrolled: (1) you; (2) your Spouse or Domestic Partner; and (3) any new Child. You must notify the HR Service Center and request enrollment within 60 days after the date of the birth, adoption, or placement for adoption. The Child must be born, adopted or placed for adoption within nine months of the date you terminate active employment.

Coverage will begin on the date of the birth, adoption, or placement for adoption.

Loss Of Other Coverage

If you or your Eligible Dependents did not enroll in this Plan previously because you were covered under another group health plan or had other health insurance coverage, you and your Eligible Dependents may enroll in the Plan during a Special Enrollment Period if the following requirements are met:

- You declined coverage (in writing if the Plan required a written statement at the time) when it was previously offered because you or your Eligible Dependents were covered under another Group Health Plan or had other health insurance coverage; and
- The other coverage was COBRA Continuation Coverage and it was exhausted; or
- The other coverage ended because
    - You lost eligibility (including as a result of divorce, legal separation, loss of dependent status, death, termination, or reduction in hours of employment, or because you no longer live or work in the other health plan service area);
    - The other coverage no longer offers any benefits to a class of similarly situated individuals; or
    - Employer contributions to the other coverage were terminated.

You must request enrollment within 60 days after the other coverage ended. You must provide satisfactory proof of the loss of other coverage if requested.

An individual who loses coverage for the following reasons is not eligible for a Special Enrollment Period:

- The individual did not pay premiums on a timely basis.
- The individual chose to drop coverage for any reason, including an increase in premium or change in benefits.

- The individual's coverage was terminated for cause, such as a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan.

Unless otherwise provided under your elected Benefit Plan, enrollment due to loss of other coverage will be effective on the day after your other coverage ends.

Medicaid/Children's Health Insurance Program Changes

If you, your Spouse, Domestic Partner or other Eligible Dependents are eligible for, but not enrolled in the benefits offered under this Plan, you are entitled to a Special Enrollment Period to elect coverage under the Plan if:

- Your coverage or the coverage of your Spouse, Domestic Partner, or other Eligible Dependent under a Medicaid plan or state Children's Health Insurance Program ("**CHIP**") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your Spouse, Domestic Partner, or other Eligible Dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Unless otherwise provided under your elected Benefit Plan, enrollment due to loss of Medicaid or CHIP coverage will be effective on the day after such coverage ends. If you qualify for a premium assistance subsidy, your coverage will be effective on the date you start receiving the subsidy.

Failure To Enroll In a Timely Manner

If you do not complete the enrollment process during your Initial Enrollment Period, or a Special Enrollment Period, you will continue with your existing coverage in the benefits offered under this Plan for the following Plan Year.

End Of Plan Participation

Your participation (and your Covered Dependents' participation) in the Plan will end on the earliest of:

- The date you (or your Covered Dependents) fail to meet the eligibility requirements or conditions described in the Plan (unless you have elected COBRA Continuation Coverage for a Benefit Plan for which COBRA is available);
- The date of a Qualifying Life Event (as defined below) that leads you to revoke your participation;
- Your (or your Covered Dependent's) failure to meet the eligibility requirements or conditions described in the Plan (unless you have elected COBRA Continuation Coverage for a Benefit Plan for which COBRA is available);

- The date on which an Inactive Employee receiving benefits from the Company's Long-Term Disability Plan ceases to be eligible for such benefits;
- If you fail to timely submit your payment for coverage, the last day of the month for which you have fully paid for your coverage;
- For Covered Dependents, pursuant to the terms of the QMCSO under which he or she participates in the Plan;
- The date your coverage is terminated for cause, for example, you commit or attempt to commit fraud against the Plan or you have been dishonest about a material matter affecting eligibility or benefits. ***In the case of fraud or intentional misrepresentation of a material fact, coverage may be retroactively terminated***; or
- The termination of the Plan by the Company.

QUALIFYING LIFE EVENTS

You cannot change your benefit elections during the Plan Year outside an enrollment period, unless you experience a "**Qualifying Life Event**" and the change you want to make is consistent with the Qualifying Life Event.

Qualifying Life Event For All Benefit Plans

You may change your Benefit Plan selections if you or your Covered Dependent becomes eligible or ineligible for coverage on account of a change in:

- Legal marital status (for example, divorce, legal separation, annulment);
- Number of Eligible Dependents (for example, death; or birth, adoption, or placement for adoption within the first nine months after your retirement/termination of active employment);
- A Covered Dependent's status (that is, a family member becomes ineligible for benefits under the Plan);
- Coverage by your spouse or other Covered Dependent permitted under the spouse's or Covered Dependent's employer's benefit plan due to a Qualifying Life Event. However, please note that losing COBRA coverage does not qualify as a Qualifying Life Event and will not make your spouse or dependent eligible for coverage; or
- The availability of benefit options or coverage under any of the Benefit Plans under the Plan (for example, an HMO is added to or deleted from the Medical and Prescription Drug Plan for your classification).

Additional Qualifying Life Events For Healthcare Options

In addition to the above Qualifying Life Events, you may also change elections for the Medical and Prescription Drug Plan, or Dental Plan if:

- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child

Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child; or

- You, your spouse, or other Covered Dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines).

Consistency Rule
Your election change must be consistent with the Qualifying Life Event that affects your coverage under a Benefit Plan. For example, if one of your family members no longer qualifies as a Covered Dependent, you could cancel coverage for that family member, but you could ***not*** cancel coverage for your other Covered Dependents.

If you are not sure the election change you would like to make is consistent with the Qualifying Life Event, you should contact the HR Service Center.

Procedures For Changing Mid-Year Elections
If you want to change an election because of a Qualifying Life Event, you must notify the HR Service Center of the event that resulted in the change and update any forms that the HR Service Center may require. You will be required to provide additional documentation for certain Qualifying Life Events, for example, a birth certificate if you wish to add a new Child to your benefits coverage within the nine month period immediately following your retirement/termination of active employment. The change request must be filed on or before the date that is 60 calendar days after the date of the Qualifying Life Event. The change in coverage generally will be effective as of the date of the qualifying life event. If one or more months have passed since the Qualifying Life Event, additional Benefit Contributions will be required to place you in the position you would have been in had your new election been in effect at the date of the Qualifying Life Event.

If you file a request for a change in coverage more than 60 days after the date of the Qualifying Life Event, the requested change will not take effect, and you will have to wait until the next Open Enrollment Period, or until you experience another consistent Qualifying Life Event to make the change.

BENEFIT PLANS

MEDICAL AND PRESCRIPTION DRUG PLAN

For a full description of the Medical and Prescription Drug Plan benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Plan Information Chart.

Available Coverage Options
The Medical and Prescription Drug Benefit Plan options available to Retirees and Inactive Employees depends on the date of retirement:

Individual's Status	Available Coverage Options
If you retired before 1/1/1995	Blue Cross Blue Shield of MI PPO option
If you retired on or after 1/1/1995:	
• If all covered family members are under age 65	Blue Cross Blue Shield of Michigan PPO or HDHP/HSA options
• If the Retiree is under age 65 and covers a Medicare eligible dependent	Blue Cross Blue Shield of Michigan PPO or HDHP/HSA options
• If retiree is over age 65 and covers a non-Medicare eligible dependent	Blue Cross Blue Shield of Michigan PPO
• If all covered family members are over age 65	Medicare coverage available through the Aon Retiree Coverage Exchange
Inactive Employee*	Blue Cross Blue Shield of Michigan PPO
Surviving spouse or domestic partner of Retiree or Inactive Employee	
• If you became a surviving spouse or domestic partner before January 1, 2015 and—	
o You are under age 65	Blue Cross Blue Shield of Michigan PPO or HDHP options
o You are over age 65	Blue Cross Blue Shield of Michigan PPO
• If you became a surviving spouse or domestic partner on or after January 1, 2015 and—	
o You are under age 65	Blue Cross Blue Shield of Michigan PPO or HDHP options
o You are over age 65	Medicare coverage available through the Aon Retiree Coverage Exchange

Individual's Status	Available Coverage Options
Surviving child of Former Employee or Inactive Employee	
• If you became a surviving child before January 1, 2015, and are—	
○ Under age 26	Blue Cross Blue Shield of Michigan PPO or HDHP options
○ Disabled and over age 26	Blue Cross Blue Shield of Michigan PPO
• If you became a surviving child on or after January 1, 2015, and are—	
○ Under age 26	Blue Cross Blue Shield of Michigan PPO or HDHP options
○ Disabled and over age 26 but under age 65	Blue Cross Blue Shield of Michigan PPO
○ Disabled and over age 65	Medicare coverage available through the Aon Retiree Coverage Exchange

*Inactive Employees who are receiving LTD benefits are eligible on the first day of the Plan Year following the commencement of disability benefits to enroll in the Blue Cross Blue Shield of Michigan PPO coverage option. Benefits provided through the end of the year in which disability benefits commence will be provided under the terms of the Dow Corning Health and Welfare Benefits Plan For Active Employees.

Premium Subsidies

If you are a Retiree or Inactive Employee (or the surviving spouse or child of a Retiree or Inactive Employee) who was hired on or after January 1, 2006, you are not eligible for a subsidy, but will have access to Medicare coverage through the Aon Retiree Health Exchange.

If you are a Retiree or Inactive Employee (or surviving spouse or child of a Retiree or Inactive Employee) who was hired prior to January 1, 2006, you may qualify for one of the following premium subsidies for your medical coverage:

Former Employees retired prior to January 1, 1995

If you signed a benefit agreement at the time of your retirement, you will receive the subsidy set forth in your benefit agreement. If you did not sign a benefit agreement at the time of your retirement, you will receive the annual, adjustable subsidy that the Company communicates to you on an annual basis.

Former Employees retired on or after January 1, 1995

Retiree Group	**Annual Subsidy Amount**
If the Retiree is under age 65 and all covered dependents are under age 65 OR the Retiree is under age 65 and one or more covered dependents is eligible for Medicare.	Up to $6,000 for each covered individual (up to a family maximum of $18,000), which may be pro-rated based on your years of service, unless you meet one of the following requirements: - Age 60 with at least 10 years of service - 30 years or more of service, or - 85 points
If the Retiree is over age 65 and covers one or more non-Medicare eligible dependents.	Up to $3,000 for each covered individual, up to a family maximum of $9,000.
If the Retiree is over age 65 and all covered dependents are eligible for Medicare.	If you are eligible to retire on or before December 31, 2015, you will receive a subsidy of $2,000 for each covered individual, which may be adjusted annually for inflation, capped at $2,400 per covered individual. If you first become eligible to retire on or after January 1, 2016, then you will receive a subsidy of $2,000 for each covered individual.

Inactive Employees

For as long as you are an Inactive Employee and up to the date you are considered retired, you will pay the contribution amount communicated to you annually. Once you are considered retired, you will begin receiving the same subsidy as a Former Employee (see above). The following will be treated as your date of retirement:

- If you became disabled before reaching age 60, the date you reach age 65.
- If you became disabled between ages 60 and 64, the date five years after you received your first payment under the Long-Term Disability Plan;
- If you became disabled between ages 65 and 68, the date you turn age 70;
- If you became disabled at age 69 or older, the date 12 months after you received your first payment under the Long-Term disability Plan.

Surviving Spouse

If you are a surviving Spouse of a Retiree or Inactive Employee who was hired on or after January 1, 2006, you are not eligible for a subsidy.

If you are a surviving Spouse of a Retiree or Inactive Employee who was hired prior to January 1, 2006, and eligible to participate in the Plan, you are entitled to a subsidy for the medical coverage under this Plan. The subsidy that you will receive will depend on the date that you became a surviving Spouse:

If you became a surviving Spouse on or before December 31, 2014	If the Retiree or Inactive Employee signed a benefit agreement at the time of retirement, you will receive the same subsidy set forth in that agreement.

	Otherwise, you will receive the annual, adjustable subsidy that the Company communicates to you on an annual basis.
If you became a surviving Spouse on or after January 1, 2015 of a Retiree or Inactive Employee who retired prior to January 1, 1995.	If the Retiree or Inactive Employee signed a benefit agreement at the time of retirement, you will receive the same subsidy set forth in that agreement. Otherwise, you will receive the annual, adjustable subsidy that the Company communicates to you on an annual basis.
If you became a surviving Spouse on or after January 1, 2015 of a Retiree or Inactive Employee who retired on or after January 1, 1995	You will receive the same subsidy amount that the Retiree or Inactive Employee was entitled to receive (see the section above for Former Employees retired on or after January 1, 1995).
Surviving Child	
If you are the surviving Child of an Retiree or Inactive Employee and eligible to participate in the Plan, will receive the same subsidy as a Surviving Spouse (see above), except that your subsidy will end once you are no longer eligible to participate in the Plan.	

DENTAL PLAN

For a full description of the Dental Plan benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Plan Information Chart. The Company will communicate to you annually the contribution amount you are required to pay in order to participate. Only Retirees under age 65 and Inactive Employees are eligible to enroll in the Dental Plan.

LTD PLAN

For a description of the LTD Plan benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Plan Information Chart. The Company will communicate to you annually the contribution amount you are required to pay in order to participate. Only Inactive Employees who are receiving LTD benefits as of the date of their termination of active employment remain eligible to receive benefits under the LTD Plan.

LIFE INSURANCE PLAN

For a description of the Life Insurance Plan benefits, please refer to the Booklet provided by the Claims Administrator listed in the Benefit Plan Information Chart. The Company will communicate to you annually the contribution amount you are required to pay in order to participate. Retirees under age 65 are eligible for Basic Life, AD&D, Optional Life and Dependent Life insurance coverage. Retirees age 65 and older are eligible for Basic Life insurance coverage. Inactive Employees are eligible for Basic and Optional life insurance coverage.

IMPORTANT INFORMATION ABOUT THE PLAN

CLAIM FILING AND REVIEW PROCEDURES

Whenever you wish to receive benefits under the Plan, you must file a Claim for benefits with the Plan. Only those Claims that are for covered benefits under the Plan will be paid to you or a health care provider on your behalf. A "**Claim**" is any request for a Plan benefit made by a claimant in accordance with the Plan's reasonable procedures for filing benefit Claims, or an allegation by a claimant that the Plan Administrator, a Plan fiduciary, or the Company has violated ERISA or the Code. If your Claim is denied, you have a right to an appeal of that denial by the Claims Administrator. The Plan's procedures for filing a Claim and for requesting an appeal of a denied Claim are explained below and may differ depending on the kind of Claim that is filed.

Time limits apply to you for filing a Claim, providing more information to complete a Claim, and appealing a denied Claim. The Claims Administrator also must comply with time limits for notifying you of an improper or incomplete Claim, deciding your initial Claim, and reviewing your appeal of denied Claim. At the end of this section, a Claim Procedures Time Limits Chart lists all these time limits.

For purposes of these Claim filing and appeal procedures, the entity or individual that is responsible for determining your Claim under a particular Benefit Plan is always referred to as the "**Claims Administrator.**" This reference applies to the Plan Administrator or a third party hired by the Plan Administrator for the Self-funded Benefit Plans. Refer to the Benefit Plan Information Chart for the Claims Administrator for each Benefit Plan. The Claims Administrator who reviews an appeal of a denied Claim may be different than the Claims Administrator who reviews the initial Claim.

To be properly payable all benefit Claims must be substantiated by information from a third-party that is independent of you, your Spouse/Domestic Partner or your Eligible Dependents. This information must include, (1) a description of the service, treatment, supply, or product, (2) the date on which you received or underwent the service, treatment, procedure, or supply, or the date on which you purchased the product, and (3) the amount charged for the service, treatment, supply, or product. No Claim will be paid or reimbursed prior to the date on which the expense was incurred, except for advanced payment for orthodontia procedures, if required by the dental provider.

General Procedures For All Benefit Plans

Authorized Representatives

You may appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit Claim that you file or any appeal of a denied Claim that you choose to pursue. The HR Service Center has forms that you may fill out at any time, identifying for the Plan the person you wish to appoint as your authorized representative. The Plan will only recognize the person you have authorized on the last dated form you filed with the Plan. For the Medical and Prescription Drug Plan and Dental Plan your healthcare provider with knowledge of your condition will also be treated as your authorized representative. If you have not appointed a representative, the Claims Administrator will communicate with you directly. If you have appointed an authorized representative, the Claims Administrator will generally send you copies of

written communications that the Claims Administrator has with your representative, but in some circumstances may communicate with your representative. Claims may be filed and an appeal of any denied Claim may be sought by any employee participating in the Plan, any Covered Dependent, or any properly authorized representative.

Notice Of Initial Claim Denial

If your initial Claim under any Benefit Plan is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Initial Claim Denial**"). Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was incurred or whether the expense itself is eligible for reimbursement.

Any Notice of Initial Claim Denial must:

- Inform you of the specific reasons(s) for the denial of your initial Claim;
- Inform you of the pertinent Plan provisions on which the denial is based;
- Provide an explanation of applicable internal and external appeal procedures, including applicable time limits;
- Contain a description of any additional materials necessary to perfect your Claim, and an explanation of why this material is necessary;
- Include a statement that you have a right to bring a civil action in court if your Claim has been denied after you have asked for and received a review of the initial denial;
- For the Medical and Prescription Drug Plan and Dental Plan, reference any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and include a statement that a copy of the rule, guideline, or protocol may be obtained upon request at no charge; and
- when applicable provide contact information for an office of health insurance consumer assistance.

If your Claim is an Urgent Care Claim, the notification will also explain the expedited review process available for such claims.

Notice Of Denial On Appeal

If you appeal the initial denial of your Claim, and your Claim is denied in whole or in part on appeal, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Denial on Appeal**"). Any Notice of Denial on Appeal must:

- Inform you of the specific reasons(s) for the denial;
- Inform you of the pertinent Plan provision(s) on which the denial is based;

- Provide an explanation of the voluntary levels of appeal and external review that the Plan makes available, if any, including applicable time limits applicable to the voluntary appeal procedures (the Plan's voluntary appeal procedures may include arbitration, even binding arbitration, but any arbitration will be offered at no cost to you);
- Contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- Reference any rule, guideline, protocol, or similar document or criteria relied on in denying the Claim on appeal, and include a statement that a copy of the rule, guideline or protocol may be obtained upon request at no charge;
- For the Medical and Prescription Drug Plan and Dental Plan, contain a statement that, because your Claim was denied on appeal you may seek to have your Claim paid by bringing a civil action in court; and
- when applicable, provide contact information for an office of health insurance consumer assistance.

The claims appeal process for your Claim may require one or two levels of appeal. The decision of the Claims Administrator following the last required level of appeal is final, unless you elect to proceed to an additional voluntary level of appeal or file a suit in federal court.

Court Review And Failure Of The Claimant To Follow These Procedures

All decisions of the Claims Administrator will be final and binding. If your Claim is denied in whole or in part after all stages of these procedures have been completed (except any voluntary levels of appeal), you will have the right to seek to have your Claim paid by filing a civil action in court, but you will not be able to do so unless you have completed all of the levels of appeal (except any voluntary levels) required under the Plan. If you do not follow and complete these procedures, an appeal of your Claim in court will be subject to dismissal for your failure to exhaust your Claim and appeal rights under the Plan. This requirement that you must exhaust the Plan's Claim filing and appeal procedures applies not only to Claims for benefits, but also to Claims that the Plan Administrator, a Plan fiduciary, or the Company has violated ERISA or the Code and to decisions rescinding coverage. If you wish to file your Claim in court, you must do so within one year of the date on which you receive Notice of the Denial on Appeal. This one year limitation requirement applies to Claims for benefits, Claims alleging statutory violations of ERISA or the Code, or Claims that both seek benefits and allege statutory violations.

Failure Of The Claims Administrator To Follow These Procedures

If the Claims Administrator fails to substantially comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat these procedures as having been completed, and immediately seek any available external review or file your Claim in court. You must, however, file your Claim in court within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims For The Medical and Prescription Drug Plan and Dental Plan

Filing A Claim

Under the Medical and Prescription Drug Plan and Dental Plan, there are different types of Claims. The type of Claim filed will determine the time periods for the decisions relating to these Claims and where and how you will need to file the Claim. Under the Medical and Prescription Drug Plan, a Claim may be a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim. The prescription drug and dental claims generally only have Pre-Service and Post-Service Claims.

If you have properly filed your Claim, but have not provided sufficient information about the treatment, service, or procedure, the Claims Administrator will notify you that more information is needed and will:

- Describe the information that is needed,
- Request an extension of time in which to decide the Claim, and
- Tell you that the information must be received within 45 days from the date you receive the extension notice or your Claim will be denied.

If you provide information, but it again turns out to be insufficient, the Claims Administrator will deny your Claim.

Except for the Urgent Care Claims, the Claims Administrator may also ask for an extension of time to decide your Claim (other than for insufficient information), but only if the reason(s) for the requested extension are beyond the control of the Claims Administrator. The extension notice will contain an explanation as to why the Claims Administrator needs the extension and the date by which your Claim will be decided.

The Claims Administrator will make its decision on your initial Claim no later than the time periods indicated in the Claims Procedures Time Limits Chart at the end of this section. (You may find additional information on these procedures in the Booklets provided by the Claims Administrator.)

Pre-Service Claims

A Pre-Service Claim is a Claim for a benefit under the Plan that is conditioned, in whole or in part, on your obtaining advanced approval of the benefit before obtaining the medical care (for example, pre-authorization or pre-certification). A pre-service claim may be for non-urgent care or urgent care. Throughout this SPD, reference to a "**Pre-Service Claim**" is to a non-urgent pre-service claim, and a pre-service claim for urgent care is referred to as an Urgent Care Claim.

In most cases, your health care provider will submit your Pre-Service Claims for you. Pre-Service Claims may be made by mail, telephone, or electronic media to the Claims Administrator for your benefit options listed in the Benefit Plan Information Chart at the end of this Plan. If you or your health care provider have not submitted a proper Pre-Service Claim under the Plan's Claims procedures, the Claims Administrator will notify you verbally, unless you request written notice, and explain what steps you must take to properly file your Claim.

Approval of your Pre-Service Claim serves only to meet the Plan's pre-authorization or pre-certification requirement so that you will not be penalized. Pre-certification approval is not a guarantee that the Claim will be paid in full, as there may be other reasons to deny your Claim. Once the treatment is provided, the provider's bill will be processed as a Post-Service Claim.

Urgent Care Claims

An "**Urgent Care Claim**" is one where applying the standard time frames for Pre-Service Claims:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- Would, in the opinion of a physician with knowledge of your medical condition, cause you severe pain that cannot be managed adequately without the care or treatment that is the subject of the Claim.

If the physician does not give this opinion, the Plan will determine whether the Claim is an Urgent Care Claim using the judgment of a prudent layperson with average knowledge of health and medicine.

In most cases, your health care provider will submit your Urgent Care Claims. All Urgent Care Claims must be made to the Claims Administrator found on the Benefit Plan Information Chart. You can submit Urgent Care Claims orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. If you or your health care provider have not submitted a proper Urgent Care Claim under the Plan's Claims procedures, the Claims Administrator will notify you verbally, unless you request written notice, and explain what steps you must take to properly file your Claim.

Other than requests for additional information, there are no extensions of time for determining Urgent Care Claims.

Post-Service Claims

A "**Post-Service Claim**" is any Claim that is not a Pre-Service or Urgent Care Claim. It is a request for the Plan to pay Benefit Plan expenses that you have already incurred. If you receive treatment from a provider who is part of a network, present your identification card (or, if no identification card is issued, your other required information) when you receive the treatment, and the provider will send the necessary information directly to the Claims Administrator.

If you have either paid for services out of your own pocket, or the provider has sent a bill directly to you for payment, you must obtain a Claim form from the HR Service Center or the Claims Administrator. You must provide in writing, either by mail or by any reasonably available electronic media, to the Claims Administrator listed in the Benefit Plan Information Chart for your benefit option, the Claim form, the bill, and if you have already paid the bill, evidence that you paid (for example, a cancelled check or a receipt or a marked "paid" invoice, etc.), and the following information:

- The contract number printed on your identification card for the benefit option;
- The name and address of the provider;
- The provider's tax identification number (if known);
- The patient's name, address, and Social Security number;
- The name, address, and Social Security number of the Plan Participant;
- The relationship of the patient to the Participant;
- The name and group number of the health plan;
- The date and place of the treatment;
- A description of the treatment, if not already noted on the invoice; and
- Any other information, documents or explanatory materials that you believe support your Claim.

Concurrent Care Claims

If you have been approved for a course of treatment under the Medical and Prescription Drug Plan, and (a) it is determined that coverage for your course of treatment is to be reduced or terminated before the treatment is completed (whether that is measured by a pre-set time period or a pre-set number of treatments), or (b) you wish to extend the course of treatment beyond what was initially authorized, you may file a "**Concurrent Care Claim**" seeking to restore the remainder of the treatment regimen previously approved, or to request an extension of the treatment. You must submit any and all information in support of your Concurrent Care Claim to the Claims Administrator listed in the Benefit Plan Information Chart.

Internal Claim Review Procedures

For Pre-Service, Urgent Care, and Concurrent Care Claims, the Claims Administrator will notify you of the initial Claim decision. For Post-Service Claims, the Claims Administrator may only notify you if the Claim is denied. In all cases where your Claim has been denied, in whole or in part, you will receive a written Notice of Initial Claim Denial, except for Urgent Care Claims, in which case you may be notified first orally, and then a written or electronic notice will be sent within three days.

If you receive a Notice of Initial Claim Denial and you disagree with that decision, you must file an appeal of that decision by submitting your appeal to the Claims Administrator listed in the Benefit Plan Information Chart. For Urgent Care Claims, a request for an expedited appeal may be submitted orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. For Pre-Service, Post-Service, and Concurrent Care Claims, your appeal must be in writing, and transmitted either by mail or any reasonably available electronic media. Your appeal must include an explanation of why you think your Claim should not have been denied and any additional information, materials, or documentation supporting your Claim.

Depending on the Claims Administrator for these health Benefit Plans, you may have one or two required levels of appeal and voluntary levels of appeal. Refer to each Benefit Plan's Booklet to find out whether the Claims Administrator has one or two required levels of appeal or any voluntary levels of appeal.

Certain benefit claims are eligible for a second level of review by the Dow Corning Corporation Appeals Board. This Appeals Board is governed by a set of bylaws, and is comprised of a combination of management and union representatives. The Appeals Board will hear claims regarding eligibility for the Plan in general, and will serve as the last internal appeal of the Plan for the following benefits: Medical and Prescription Drug Program and Dental Program.

The person(s) reviewing your appeal will grant no deference to either the original Claim denial or the first-level appeal decision, if applicable, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the person(s) reviewing your appeal will not be the same person(s) who made the initial decision or reviewed the prior appeal (if any), nor will they be subordinate(s) of those individuals. You will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial or the first-level appeal of your Claim, if applicable, is based on medical judgment (for example, it was based on an assessment that your treatment was experimental or was not medically necessary), the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

You will be notified in writing of each decision on appeal, whether favorable or adverse, within the time frames listed in the Claims Procedures Time Limits Chart. Notice of the results of an appeal of an adverse Urgent Care Claim determination may be provided orally, as long as a written or electronic notice is sent within three days.

If the Benefit Plan option has two required levels of appeal and you disagree with the first-level appeal decision, you must complete a second level of appeal on your Claim (other than for an Urgent Care Claim, for which there is no second level of appeal available). You must submit your request for second-level appeal to the Claims Administrators listed in the Benefit Plan Information Chart.

External Review for a Non-Grandfathered Medical Program

Once you have exhausted the internal appeals procedures described above, you or your authorized representative have the right to request an external review from an Independent Reviewing Organization ("**IRO**"). The Notice of Denial on Appeal will contain an explanation on how to submit information to the IRO. This external review procedure is voluntary and you are not required to use this level of appeal in order to have the Claim determined by a court.

Generally, you will have the right to seek an external appeal if your Claim was denied because of a medical judgment, such as medical necessity, appropriateness, health care setting, level of care or effectiveness, or because of a rescission of coverage. You will have up to four months to file an external appeal.

If your Claim is an Urgent Care Claim, the external review will be conducted as expeditiously as possible. If the Claim concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services, and you have not been discharged from the facility, you may also request an expedited review.

If the Claim involves experimental or investigational treatments, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

You will have an opportunity to provide additional materials to the IRO regarding the Claim once the external review is initiated. You will receive instructions directly from the IRO on how to supply additional information.

The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. After reviewing all of the information available to you and the Plan, the IRO will recommend whether the Plan should uphold or reverse the final determination of the Claim.

The IRO's decision is binding on the Plan and you, except to the extent that other remedies are available under State or Federal law.

For more information about rights to an external review, you can contact the Employee Benefits Security Administration at 1 (866) 444-EBSA (3272).

Claims For The LTD Plan

Filing A Claim

To file a Claim for LTD benefits, you may obtain a Claim form from the HR Service Center or by contacting the Claims Administrator. You must send the completed form and any materials or documentation to the Claims Administrator's address found in the Benefit Plan Information Chart.

The Claims Administrator will make its decision on your initial Claim within a reasonable time but no later than the time periods indicated in the Claims Procedures Time Limits Chart at the end of this section. The Claims Administrator may, however, extend the time periods, as long as the Claims Administrator determines that an extension is necessary due to matters beyond its control, and the Claims Administrator notifies you in a timely manner of why it needs the extension, and the date by which the Claims Administrator expects to decide your Claim. The notice of extension will:

- Explain the standards on which entitlement to a benefit is based,
- Indicate the unresolved issues that prevent a decision on the Claim,

- Describe the additional information that is needed to resolve those issues and
- Tell you that the information must be received within 45 days from the date you receive the notice of extension or your Claim will be denied.

If the Claims Administrator requests additional information, but it again is insufficient, the Claims Administrator will deny your Claim.

Claim Review Procedures

If you receive an adverse benefit determination on an LTD Claim and you disagree with the decision, you must request that the Claims Administrator review the decision. An appeal of a denied Claim must be made to the Claims Administrator at the address found in the Benefit Plan Information Chart. Your appeal must be in writing and must include an explanation of why you think your Claim should not have been denied. Include any documentation you believe supports your Claim.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

The review of your appeal will take into account all comments, documents, records, and other information submitted by you relating to your Claim, even if that information was not submitted or considered in the initial decision of your Claim.

The person(s) reviewing your appeal will grant no deference to the initial Claim denial, or the first level of appeal decision, if any, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the person(s) reviewing your appeal will not be the same person(s) who made the initial determination, nor will they be subordinate(s) of those individuals. You will also be provided reasonable access to and copies of, all documents, records and other information relevant to your Claim.

If the initial Claim denial (or the first level of appeal decision, if any) was based on a medical judgment, the Claims Administrator will consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

The Claims Administrator may have one or two required levels of appeal and voluntary levels of appeal. Refer to each Benefit Plan's Booklet to find out whether the Claims Administrator has one or two levels of appeal or any voluntary levels of appeal. If the Claims Administrator has two required levels of appeal and you disagree with the first-level appeal decision, you must complete a second level of appeal on your Claim. You must submit your request for second-level appeal to the Claims Administrator listed in the Benefit Plan Information Chart.

The Claims Administrator will notify you in writing of each decision on appeal, whether favorable or adverse, within a reasonable time period but no later than the time frames listed in the Claims Procedures Time Limits Chart.

Claims Based Solely on Eligibility to Participate in the Plan or a Benefit Program

Filing A Claim

If for any reason you believe you have been improperly excluded from the Plan or from any of the Plan's Benefit Programs, you may file a formal Claim in writing to the Plan Administrator. Be sure to state:

- why you think you should be entitled to participate in the Plan or in a particular Benefit Program,
- why you think you have not been permitted to participate and
- your name and Social Security number.

Notice of the decision on your Claim to participate will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

This procedure only applies to a Claim that deals solely with eligibility to participate in the Plan or a particular Benefit Program. It will not apply to eligibility determinations that are linked to a Claim for a specific benefit under a particular Benefit Plan. In those instances, your Claim will be decided under the procedures that apply to the specific benefit you are seeking.

Decision On Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

Claim Review Procedures

If your Claim for eligibility to participate in the Plan or one of its Benefits Programs is denied, in whole or in part, and you disagree with this decision, you must make a written appeal to the Plan Administrator for a review of the denial of your Claim. Your appeal must be submitted to the Plan Administrator at the address listed in the section Other Important Provisions.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim to participate. You may also submit written comments, documents, records, and other information relating to your appeal to the Plan Administrator.

The review on your appeal will take into account all comments, documents, records, and other information submitted by you relating to your appeal, even if that information was not submitted or considered in the initial decision of your Claim. The Plan Administrator will make its decision on your appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits Chart.

Claims Procedures Time Limits

Time Limits For The Medical and Prescription Drug Plan and Dental Plan

	Pre-Service Claims	Urgent Care Claims	Post-Service Claims	Concurrent Care Claims
Claims Administrator's Notice of Improper Pre-Service Claim	**5 days** after receiving improper Claim.	***24 hours** after receiving improper Claim.	**N/A**	**N/A**
Claims Administrator's Notice of Incomplete Claim	**N/A**	**24 hours** after receiving incomplete Claim.	**N/A**	**N/A**
Participant Deadline to Complete Urgent Care Claim	**N/A**	**48 hours** after receiving notice of improper or incomplete Claim	**N/A**	**N/A**
Claims Administrator's Notice of Initial Claim Denial	****15 days** after receiving the initial Claim. **30 days** after receiving the Claim if Claims Administrator needs more information and if Claims Administrator provides an Extension Notice during initial 15-day period.	****48 hours** after receiving completed Claim or after the 48-hour Participant deadline, whichever is earlier. **72 hours** after receiving the initial Claim, if it was proper and complete.	**30 days** after receiving the initial Claim. **45 days** after receiving the Claim if Claims Administrator needs more information and if Claims Administrator provides an Extension Notice during initial 30-day period.	**24 hours** after receiving the Claim involving Urgent Care. All other Concurrent Care Claims will be decided quickly enough so that Participant will have sufficient time to appeal that decision before the course of treatment terminates as originally scheduled, but no later than five days after the date it was decided.
Participant Deadline to Complete Non-Urgent Claim	**45 days** after receiving Extension Notice	**N/A**	**45 days** after receiving Extension Notice	**N/A**
Participant Deadline to Appeal decision	**180 days** after receiving Claim denial.	**180 days** after receiving Claim denial.	**180 days** after receiving Claim denial.	In time to continue course of treatment uninterrupted.
Claims Administrator's Notice of Appeal Decision	**30 days** after receiving the appeal. **15 days** after receiving an appeal if Claims Administrator requires two levels of appeal. No extensions for decisions on appeal.	**72 hours** after receiving appeal. No extensions for decisions on appeal.	**60 days** after receiving the appeal. **30 days** after receiving an appeal if Claims Administrator requires two levels of appeal. No extensions for decisions on appeal.	**72 hours, 30 days or 60 days** after receiving an appeal (depending on the nature of the Claim), if Claims Administrator has one level of appeal. **72 hours, 15 days or 30 days** after receiving an appeal (depending on the nature of the Claim), if Claims Administrator requires two levels of appeal. No extensions for

	Pre-Service Claims	Urgent Care Claims	Post-Service Claims	Concurrent Care Claims
				decisions on appeal.
Participant Deadline to Appeal First-Level Review Decision	**60 days** after receiving denial of the first-level appeal, or **180 days** after receiving Claim denial, whichever is later	**N/A**	**60 days** after receiving denial of the first-level appeal, or **180 days** after receiving Claim denial, whichever is later	In time to continue course of treatment without interruption.

* The Claims Administrator will give this Notice as soon as possible, but no later than the stated time period.

** The Claims Administrator will give this Notice within a reasonable period of time appropriate to the medical circumstances, but no later than the stated time period.

Time Limits for a Non-Grandfathered Medical Program External Review Procedures

	Standard Review	Expedited Review
Participant's Deadline to Submit Request for Voluntary External Review	**4 months** after receiving final denial on appeal	*May request an expedited external review when the claim is initially denied if taking the time to complete an internal appeal with the Claims Administrator would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function. May also request an expedited external review following the internal appeal process if (1) the taking the normal time frame for an external review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function; or (2) the internal claim appeal involves an admission, availability of care, continue stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
Claims Administrator's Deadline for Completing Preliminary Review to Determine Whether Claim is Eligible for External Review	**5 business days** after receiving request for external review	**Immediately**
Claims Administrator's Deadline for Notifying Claimant of Preliminary Review Outcome or Incomplete Request	**1 business day** after completing preliminary review	**Immediately**

	Standard Review	Expedited Review
Participant's Deadline for Responding to Notice that Request for External Review is Incomplete	**Before the remainder of the 4-month filing deadline has expired,** or within **48 hours** following receipt of the notification, whichever is later.	*Participant should respond as soon as possible
Participant's Deadline for Submitting Additional Information to Independent Review Organization	**10 business days** after receiving notice from the Independent Review Organization that it has accepted the claim for review	*Participant should respond as soon as possible
Independent Review Organization's Notice of Final External Review Decision	**45 days** after the Independent Review Organization receives the request for external review.	**72 **hours** after receiving appeal (with written notice to follow within 48 hours).

*The deadline is the same as for a Standard Review.
**The Independent Review Organization will provide this Notice as expeditiously as the medical circumstances require, but no later than the stated time period.

Time Limits For The LTD Plan

Claims Administrator's Notice of Initial Claim Denial	**45 days** after receiving the initial Claim **75 days** after receiving the Claim if the Claims Administrator needs more information or needs more time for reasons beyond its control and Claims Administrator provides notice during the initial 45-day period **105 days** after receiving the Claim, if the Claims Administrator needs more information and if Plan provides notice during the initial 30-day extension period.
Participant Deadline to Provide Additional Information (if applicable)	**45 days** after receiving notice of extension from the Claims Administrator.
Participant Deadline to Appeal Decision	**180 days** after receiving the Claim denial.
Claims Administrator's Notice of Appeal Decision	**If the LTD Program has two appeal levels, 45 days after receiving the appeal.** **If the LTD Program has one appeal level, 90 days after receiving the appeal.**

Time Limits For Plan and Benefit Program Eligibility Appeals

Claims Administrator's Notice of Initial Claim Denial	**90 days** after receiving the initial Claim. **180 days** after receiving the Claim if the Claims Administrator needs extension for special circumstances and if Claims Administrator provides an extension notice during initial 90-day period.

Participant Deadline to Appeal Decision	**60 days** after receiving the Claim denial.
Claims Administrator's Notice of Appeal Decision	**60 days** after receiving the request for appeal. **120 days** after receiving the request for appeal if Claims Administrator needs an extension.

SPECIAL RULES FOR THE HEALTHCARE PROGRAMS: MEDICAL AND PRESCRIPTION DRUG PLAN AND DENTAL PLAN

General Exclusions

No benefits are payable for any expense or portion of an expense under the Medical and Prescription Drug Plan and Dental Plan:

- Due to an injury or illness arising out of or in the course of employment or in the course of any activity you undertake for wage or profit;
- For any expense where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under this Plan;
- For expenses for services, care or supplies that are rendered or received prior to or after any period of coverage under this Plan, except as specifically provided under this Plan;
- For services or treatment given by an immediate family member (parent, grandparent, spouse, Child, grandchild or sibling) or a person residing in the same household as the patient;
- For expenses that the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government; or
- For benefits that are provided, or that would have been provided had the Participant enrolled for them, under Medicare, except as provided in the section titled "Coordination with Medicare."

Coordination Of Benefits

For coordination of benefit rules that apply to insured benefits, please see the applicable insurance policy. With respect to the Self-funded benefits, the Plan will coordinate with:

- Another "**Group Health Plan**" (including any employer-sponsored welfare benefit plan, whether or not insured, that provides medical or dental coverage, including prescription drugs), such as insurance provided by a Spouse's or Domestic Partner's employer;
- Automobile accident insurance; and
- Funds that could be recovered by you or your Covered Dependent from another person or entity who caused the injuries on account of which a Claim was made.

When the Plan coordinates benefits, one source of benefits will be "**Primary**" (that is, it will pay before the other source). The other source will be "**Secondary**" (that is, it will pay after the source of benefits that is Primary).

When the Plan is Primary, it will pay benefits as if there were no other source of benefits. But if the Plan is Secondary, it will first calculate what it would pay in the absence of any other source of benefits. Then the Plan will subtract from that amount the amount that should be paid by the other source. The Plan will pay that difference, so that the Participant will receive the full amount of benefits payable under the Plan. (The amount payable by the other source will be subtracted even if you do not apply for benefits from that other source.) This Plan will not, however, pay more than it would have if it were the only source of benefits.

Coordination With Other Group Health Plans

If you and/or your Covered Dependent incur an expense that would be paid by two or more Group Health Plans, the Group Health Plan with the highest priority is Primary and will pay first. The other Group Health Plan is Secondary and will pay next.

Benefits will be paid as follows:

First: A Group Health Plan without a coordination of benefits provision will pay.

Second: Then a Group Health Plan covering the patient as an employee/former employee/inactive employee, rather than as a dependent, will pay.

Third: Then in the case of a Group Health Plan covering a patient who is a dependent and a minor Child of divorced or legally separated parents:

- If a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's Group Health Plan (that also covers the Child) will pay;
- Then a Group Health Plan that covers the Child as a dependent of a custodial parent will pay;
- Then a Group Health Plan that covers the Child as a dependent of the spouse of the custodial parent will pay;
- Then a Group Health Plan that covers the Child as a dependent of the non-custodial parent will pay.

Fourth: Then in the case of a Group Health Plan covering a patient who is a dependent and minor child of married parents, the Group Health Plan of the parent whose birthday occurs earlier in the year will pay.

Fifth: Then in the case of a Group Health Plan covering a patient who is a dependent and minor child of married parents, the Group Health Plan of the parent whose birthday occurs later in the year will pay.

Sixth: Then the Group Health Plan that has covered the patient for the longer period of time will pay.

Seventh: Then any other Group Health Plan will pay.

If two or more Group Health Plans have the same priority, they will each pay pro-rata. There are some special rules that have precedence over the above priorities.

- COBRA coverage is always Secondary to any other Group Health Plan,
- Coverage provided by virtue of being a retiree, laid-off employee, an inactive employee or an employee on a leave of absence is always secondary to coverage provided by virtue of that individual being an active employee.
- Coverage for a spouse or domestic partner will be secondary when required by the Plan's rules regarding eligibility of spouses and domestic partners (see the Plan's "Eligibility" section for more details).

Coordination With Automobile Accident Insurance

The Plan coordinates payment of its Self-funded healthcare benefits on a Secondary basis. Any state insurance law that purports to require that the Plan pay Primary or that does not allow the Plan to subrogate or recover its payments is preempted by ERISA. This means that even if you are covered under an automobile insurance policy that makes "other health coverage" Primary, the Plan will still pay Secondary for those benefits that are Self-funded.

You are considered covered under an automobile insurance policy if you are:

- An owner or principal named insured under the policy;
- A family member of a person insured under the policy; or
- A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

If you do not have automobile insurance coverage even though you are legally required to do so, the Plan will not pay more benefits than it would have paid if you had purchased the legally required automobile coverage.

Coordination With Medicare

The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary.

Medicare is available for certain people who have not yet reached the age of 65, but who have received Social Security disability benefits for at least 24 months. When Medicare is available in those situations, the Plan will be Secondary for you and/or your Covered Dependents.

Medicare is also available to individuals who have been under treatment for end-stage renal disease. The Plan will be Primary to Medicare for a covered individual who qualifies for Medicare benefits because of end-stage renal disease for the coordination

period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be Secondary.

It is your responsibility to apply for Medicare benefits that are available. If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

When coordinating with Medicare, you will be considered enrolled for Medicare coverage if you are eligible, even if you are not enrolled or you have been deemed ineligible for Medicare due to noncompliance with substance abuse treatment requirements under the Social Security Independence and Program Improvements Act of 1994. If you are age 65 or older, or qualify for Medicare because of a disability, this plan will provide secondary coverage to Medicare.

This plan does not coordinate benefits with the Medicare Part D prescription drug program. If you (or another member of your family who is covered under this plan) are eligible for and elect Medicare Part D prescription drug benefits, you (or the other family member) will not be eligible for prescription drug benefits under this plan. However, other covered members of your family that do not participate in the Medicare Part D prescription drug program will be eligible for prescription drug benefits under this plan.

Coordination with CHIP Coverage
The Plan will be considered primary to any CHIP coverage that supplements this Plan.

Coordination With Third Parties
If a third party is responsible for causing a health problem on account of which you have incurred medical expenses, the Plan is Secondary to the third party's liability to you. If benefits are available under any insurance policy as a result of the third party's conduct, the Plan is Secondary to those benefits.

Facility Of Payment
If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan's coordination provisions. The Plan will then have no further liability for those expenses or benefits.

The Plan will not pay any expense or benefit that has actually been paid by another source, even if that other source is Secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Facility of Payment provision of this Plan applies.

Subrogation/Right Of Recovery
If you or your Covered Dependents incur medical expenses for which another party may be responsible, the Plan has a right to recover benefits paid by the Plan for such expenses. The Plan has an equitable right to seek reimbursement from any payments that you or your Covered Dependents receive from such party, or the Plan may "step into the shoes" of yourself or your Covered Dependent, or your successors in interest, to bring a subrogation action against any third party that may be responsible for paying these costs. This right exists until the Plan has been reimbursed in full for the benefits it

has paid and the expenses and attorney fees the Plan has incurred in enforcing its rights.

When you and your Covered Dependents accept benefits under the self-insured programs that are part of this Plan, you assign to the Plan, or transfer to the Plan, all rights of recovery from any other party, to the fullest extent permitted by law. The Plan will be subrogated to and may bring any claim you or your Covered Dependents may have against the other party (or its insurer). You may not assign your claims to any other person without permission of the Plan. The Plan will have a first priority lien on any recovery for the total amount it has paid, as well as for any expenses or attorneys' fees incurred in enforcing the Plan's rights. The Plan may withhold payment of benefits when it appears that another party may be liable for the expenses until the liability is legally determined.

If you or your Covered Dependents receive any funds from any person who may have a responsibility to pay expenses covered by the Plan, the Plan has the right to be reimbursed from your total recovery before any amounts, including expenses or attorneys' fees, are deducted, whether or not the recovery is specifically for medical payments, and regardless of how the proceeds are characterized or the source of the recovery. This is a right of first reimbursement, and the "make whole" rule or "common fund" rule will not apply.

Without limiting the Plan's right to reimbursement or subrogation, these rights apply to any judgment, settlement or payment made or to be made because of an accident or malpractice, including but not limited to payments made by other insurance of any kind. The Plan will not pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan Administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the Plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the Plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan.

If you, your agent, a trust, or any other person or entity receives any proceeds of settlement or judgment on behalf of you or your Covered Dependent, and if the Plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the Plan. The Plan may recover any expenses it incurs because you or your Covered Dependents failed to cooperate in enforcing the Plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the Plan may be forfeited.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**") gives you and your Covered Dependents the right to continue coverage under the Medical and Prescription Drug Plan and Dental Plan beyond the time the coverage would

normally end ("**Continuation Coverage**"), under certain circumstances. COBRA Continuation Coverage can become available to you and your Covered Dependents when you or they would otherwise lose group health coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your Covered Dependents, and what you need to do in order to protect your right to receive it.

For more information about your COBRA rights under the Plan, please contact please contact Ceridian at (800) 877-7994.

You may have other, more affordable options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. When deciding whether to elect COBRA Continuation Coverage, you should investigate these other options.

Qualifying Events

COBRA Continuation Coverage is a continuation of coverage under the Medical and Prescription Drug Plan and Dental Plan when coverage would otherwise end on account of a life event known as a "**Qualifying Event.**" After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a Qualifying Event.

You may become a Qualified Beneficiary if the Company files a bankruptcy proceeding under Title 11 of the United States Code. If a proceeding in bankruptcy is filed, and the bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary. The retired employee's Covered Dependents will also become Qualified Beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

Your spouse will become a Qualified Beneficiary if coverage is lost because any one or more of the following Qualifying Events happens:

- Your death.
- You are divorced from your spouse.
- You become entitled to Medicare benefits (under Part A, Part B, or both).

Your Covered Dependent Child will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

- Your death.
- You are divorced from your spouse.
- Your Child stops being an Eligible Dependent.

- You become entitled to Medicare benefits (under Part A, Part B, or both).

Notice Of Qualifying Event Required

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the HR Service Center has been notified in writing that a Qualifying Event has occurred. When the Qualifying Event is commencement of a proceeding in bankruptcy with respect to the Company, the Company must notify the HR Service Center of the Qualifying Event.

For all other Qualifying Events (your death, divorce, your entitlement to Medicare benefits, or your Child's losing eligibility for coverage as an Eligible Dependent), you must notify the HR Service Center in writing within 60 days after the Qualifying Event occurs. Your notice must include: the name of the Retiree or Inactive Employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event, and the name(s), address(es), and Social Security number(s) of the Covered Dependent(s) affected by the Qualifying Event. Failure to notify the HR Service Center in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the HR Service Center receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or for all Covered Dependents who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, other Group Health Plans can apply pre-existing conditions exclusions to you if you have more than a 63-day gap in health coverage; election of COBRA Continuation Coverage may help you avoid a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies without pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible, such as a plan sponsored by your spouse's employer, within 30 days after your Group Health Plan coverage ends because of the Qualifying Events listed above. You will also have the

same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

Cost Of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the employer and employee contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying For COBRA Continuation Coverage

First Payment For COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the HR Service Center to confirm the correct amount of your payment.

Periodic Payments For COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the dates stated in the COBRA election forms sent to you. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods, but you are required to timely submit payment for COBRA continuation coverage even if you do not receive a periodic notice of payment due.

Grace Periods For Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 days after the first day of each coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as 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 monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and either the amount paid will be deemed payment in full for that period or you will be asked to pay the shortfall. If the notice says the shortfall must be paid and you do not pay within 30 days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration Of Coverage

COBRA Continuation Coverage may continue:

- For you, your Spouse and Covered Dependents for as long as you are alive if Dow Corning terminates this Plan within one year before or after commencing a bankruptcy proceeding under Title 11 of the United States Code, and thereafter your surviving Spouse and Covered Dependents may continue coverage for 36 months following your death;
- For your Spouse or Covered Dependents for 36 months when the Qualifying Event is your divorce, your death, your entitlement to Medicare (under Part A, Part B, or both), or your Child's loss of Eligible Dependent status.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- Any required premium payment is not paid in full on time;
- After electing COBRA Continuation Coverage, a Qualified Beneficiary:
  - Becomes covered under another employer's Group Health Plan that does not impose any pre-existing condition exclusion for a Qualified Beneficiary's pre-existing condition; or
  - Becomes enrolled in Medicare benefits, under Part A or Part B, or both; or
- The Company ceases to provide any Group Health Plan for its employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

At the end of the COBRA Continuation Coverage period, you must be allowed to enroll for individual conversion coverage, but only if this opportunity is provided under the specific Benefit Plan for which you elected COBRA Continuation Coverage.

Questions About COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the HR Service Center. For more information about your rights under ERISA (including COBRA), HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep The Plan Informed Of Any Changes Of Address

In order to protect your family's rights to COBRA Continuation Coverage, you should keep the HR Service Center informed of any changes in the addresses of family members.

HIPAA Privacy Rule

All definitions in the Health Insurance Portability and Accountability Act ("**HIPAA**") privacy regulations ("**Privacy Rules**") and security regulations ("**Security Rules**") are incorporated by reference into the Plan. If a term is not defined in the Privacy Rules or Security Rules, the term will have its generally accepted meaning.

Hybrid Entity

To the extent the Plan provides any non-health benefits (e.g., disability), only the healthcare component of the Plan is subject to these provisions.

Protected Health Information

The Company will have access to protected health information ("**PHI**") only as permitted under this Plan or as otherwise required or permitted by the Privacy Rules. PHI means information that is created or received by the Plan and relates to:

- Past, present, and future physical or mental health or condition of an individual;
- Provision of healthcare to an individual; or
- Past, present, or future payment for the provision of healthcare to an individual; and
- That identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Uses and Disclosures of PHI by the Plan

The Plan may disclose PHI to the Company only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the Company.

Plan Administrative Functions

Once the Company receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. "**Plan Administration Functions**" are administrative tasks performed by the Company on behalf of the Plan and exclude employment-related functions and functions performed by the Company in connection with any other benefit or benefit plan of the Company. Plan Administration Functions include, but are not limited to:

- Enrollment and disenrollment activities;
- Verification of participation in the Plan;
- Obtaining premium contributions;
- Determining eligibility for benefits;
- Activities to coordinate benefits with other plans and coverages;

- Final adjudication of appeals of claim denials;
- Exercise of the Plan's rights of reimbursement and subrogation;
- Assisting participants in eligibility, benefit claims matters, inquiries, and appeals;
- Obtaining premium bids;
- Evaluation of health plan design;
- Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);
- Legal services and auditing functions (including fraud and abuse detection);
- Business planning, management and general administration;
- Making claims under stop-loss or excess loss insurance;
- Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Privacy Obligations of the Company

With respect to PHI created by or received from the Plan, the Company will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company unless authorized by the individual;
- Report to the Plan any use or disclosure of PHI that is inconsistent with the Privacy Rules of which the Company becomes aware;
- Make PHI available to an individual in accordance with the access requirements of the Privacy Rules;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human

Services Secretary for purposes of determining compliance with the Privacy Rules;

- If feasible, return or destroy all PHI received from the Plan and retain no copies of that PHI when no longer needed by the Company for the purpose for which disclosure was made, (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible); and

- Ensure that adequate separation between the Plan and the Company is maintained as required by the Privacy Rules. For purposes of maintaining adequate separation between the Plan and the Company, only the employees or classes of employees identified in the Company's privacy policies and procedures ("**Authorized Employees**") will be given access to PHI. The section of the Company's privacy policies and procedures that lists these employees is incorporated by reference into this Plan. The access to and use of PHI by Authorized Employees is restricted to the Plan Administration Functions that the Company performs for the Plan. If an Authorized Employee uses or discloses PHI in ways other than those permitted by the Plan or the Privacy Rules, the Authorized Employee will be subject to the disciplinary procedures described in the Company's employee handbook. The Company may impose, at its discretion, reasonable sanctions as necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

Electronic Data Security Obligations of the Company

To the extent the Company maintains electronic PHI, the Company will:

- Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Company on behalf of the Plan as required by the HIPAA Security Rules;

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Company creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the required separation between the Plan and the Company is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

- Report to the Plan any security incident involving PHI of which it becomes aware.

Qualified Medical Child Support Orders

The HR Service Center will honor an order that is a "**Qualified Medical Child Support Order**" within the meaning of ERISA Section 609(a)(2)(A) ("**QMCSO**"). The HR Service Center, or its delegate, has full discretionary authority within the meaning of the U.S. Supreme Court's decision in Firestone Tire & Rubber v. Bruch (1989) to determine whether a medical child support order is "qualified" within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency. Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the HR Service Center will take the following steps, within 20 business days:

- Reply to the issuing court or agency if the individual is no longer employed or falls into a class of employees who are ineligible for coverage, or if dependent coverage is not provided.
- Determine if the Order or Notice conforms to the requirements of a QMCSO.
- Notify the issuing court or agency, the Participant, and the affected child(ren) if the Order or Notice is determined not to meet the requirements of a QMCSO.
- Notify the issuing court or agency of the coverage options available under the Plan and any waiting period that exists for coverage under the Plan, if applicable.
- Determine if federal withholding limits or prioritization rules permit the withholding from the Participant's income of the amount required to obtain coverage for the child(ren) specified.
- Notify the Participant of any contributions to be withheld from future pay.
- If appropriate, withhold from the Participant's income any required contributions.
- Notify the Claim Administrator, if applicable, about enrollment of the child(ren).
- Notify the issuing court or agency of the date of enrollment and the date coverage under the Plan will begin.

The Participant and each affected child have the right to request in writing, within 60 calendar days after being notified of the HR Service Center's decision, that the HR Service Center again review the status of the Order or Notice. The Participant and each affected child may present additional materials to the HR Service Center for review. The HR Service Center may request additional information or material from the Participant and/or affected child(ren). The HR Service Center must provide sufficient information for the Participant and/or affected child(ren) to understand available options and to assist in appropriately completing the Order or Notice.

Maternity Benefits
Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay shorter than the above periods. Nothing in this provision, however, requires that a woman covered under this Plan to give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Post-Mastectomy Benefits
To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following a mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

Genetic Information Nondiscrimination Act
The Plan complies with the Genetic Information Nondiscrimination Act of 2008. Participants and Eligible Dependents are not required to undergo genetic testing, nor shall the Plan use genetic information related to any Employee or family member to determine eligibility to participate in the plan or to determine any required employee contribution for any health benefit provided under the plan.

PLAN ADMINISTRATION

Plan Administrator
The Dow Corning Corporation is both the Plan Sponsor and the Plan Administrator and has sole responsibility for the administration of the Plan. The Company may delegate these responsibilities to a Health and Welfare Committee, which may delegate responsibilities to select individuals or to the HR Service Center. Members of the Health and Welfare Committee shall be appointed as set forth below in the rules governing the Committee.

The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms (including Enrollment Forms); to exercise all of the power and authority contemplated by the Employee Retirement Income Security Act of 1974, as amended, ("**ERISA**") and the Internal Revenue Code of 1986, as amended (the "**Code**") with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; to appoint investment managers and trustees; and generally do anything needed to operate, manage and administer the Plan. The discretionary authority of the Plan Administrator extends to its factual determinations, as well as its construction of Plan terms and its determination of benefit entitlements. The Plan Administrator has the necessary discretionary authority and

control over the Plan to require deferential judicial review pursuant to the U.S. Supreme Court decision in Firestone Tire and Rubber Co. v. Bruch (1980).

The Plan has other fiduciaries, advisors, and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. A person or persons to whom an allocation or delegation is made has the same amount of discretion as the Plan Administrator for matters covered by the allocation or delegation. The Claims Administrators are the fiduciaries with respect to Claims processing and benefit determinations. Refer to the Benefit Plan Information Chart for additional information relating to the Claims Administrators.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became or after it stopped being, a fiduciary.

Health and Welfare Committee
The Health and Welfare Committee shall be governed by the following rules:

Membership
Dow Corning Corporation will determine the number of members of the Health and Welfare Committee, but the number shall be no fewer than three. The Company will appoint the members and may remove or replace them at any time. Any member who is an employee shall be removed automatically upon termination of employment. A member may resign by delivering a written resignation to the Company and the secretary of the Health and Welfare Committee.

Records
The Health and Welfare Committee shall keep records of its proceedings.

Actions
The Health and Welfare Committee shall act by a majority of its members then in office. Action may be taken either by a vote at a meeting or in writing without a meeting. Any or all members may participate in a meeting by conference call or other conferencing technology. Actions of the Health and Welfare Committee may be evidenced by a written instrument, including an electronic record.

Compensation
Any member of the Health and Welfare Committee who is an employee shall serve without compensation.

Conflict of Interest
Any member of the Health and Welfare Committee who is a participant in the Plan shall not vote or act on a matter that relates solely to that participant or the participant's spouse or dependent. If that participant is the only member of the Health and Welfare Committee, the necessary actions shall be exercised by the Company.

Indemnification
The Company will indemnify each member of the Health and Welfare Committee and employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The Company may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense, or liability arising from any Committee member's or employee's action or failure to act.

Discretion
Wherever it is provided in the Plan that the Company or Plan Administrator may perform or not perform any act, or permit or consent to any action, non-action, or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to violate the Code or knowingly discriminate either for or against any Retiree or Inactive Employee, Participant, or Covered Dependent or any group of these persons.

OTHER IMPORTANT INFORMATION

Plan Name
Dow Corning Corporation Health and Welfare Benefits Plan For Retirees and Inactive Employees

Plan Number
507

Employer Identification Number
38-0495575

Plan Year
January 1 to December 31 of each year

Plan Sponsor And Agent For Service Of Legal Process
Dow Corning Corporation
General Counsel, Legal Department
P.O. Box 994
Midland, MI 48686-0994

Plan Administrator
Dow Corning Corporation
Mail #HRSC
Midland, MI 48686-0994
(989) 496-4772 or (800) 440-0772 for callers outside of the Midland exchange.

Type Of Plan
The Plan is a welfare benefit plan under ERISA.

Funding

The Company pays the cost of the Benefit Plans, other than any amounts you are required to pay to participate in each Benefit Plan ("**Benefit Contributions**") under the terms of the Benefit Plans. You will be informed of the amount of any Benefit Contributions at your Initial Enrollment Period and each Open Enrollment Period.

The benefits provided under the Plan will be paid, to the extent permitted by ERISA and the Code, from the general assets of the Company or through insurance. Nothing in this Plan will be construed to require the Company to maintain any fund for its own contributions or segregate any amount that it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Plan may be made.

Payment Obligations And Role Of Claims Administrator

For those healthcare Benefit Plans that are Self-funded, if you are covered by the Plan and either the Plan or the Company does not ultimately pay the medical expenses that are eligible for payment under the Plan for any reason, you and your Covered Dependents may be liable for those expenses.

The Claims Administrators under the Self-funded Benefit Plans merely process Claims and do not ensure that any of your medical expenses will be paid. Complete and proper Claims for benefits made by you will be promptly processed; but if there are delays in processing Claims, you will have no greater rights against the Claims Administrators than are otherwise afforded you by law.

Amendment Or Termination Of The Plan

The Company's Chief Human Resources Officer is authorized to amend, modify, or terminate the Plan on behalf of the Company at any time in any manner or with respect to any individual in his or her sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by the Code or ERISA. If the Plan is terminated or partially terminated for any reason, the benefits to which you became entitled prior to the effective date for the Plan's termination will be covered. Termination of the Plan will not reduce or eliminate your right to reduce your compensation earned before the date of termination. Any subsidiary or affiliate of the Company that has adopted the Plan cannot amend or terminate the Plan, but can terminate the participation of its employees in the Plan.

For insured benefits, the Company may amend the Plan, including the benefits provided by the Plan, by agreeing with the insurance company to amend or modify the underlying policies or contracts that, with this document, constitute the Plan. The Company may also amend an insured Benefit Program, including the benefits provided, by changing policies or insurance companies.

Compliance With Tax Law
The Plan is intended to comply with all applicable law, including the Code. However, neither the Plan, the Plan Sponsor, the Plan Administrator, nor any Plan fiduciary represents or guarantees that this Plan in fact meets the requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as former employees for purposes of the tax treatment of any contribution to any Benefit Plan are not eligible to participate in the Plan.

Limitation Of Rights
The Plan does not constitute a contract between you and the Company. Nothing contained in the Plan gives you the right to be retained or reemployed in the service of the Company or to interfere with the right of the Company to sever the employment relationship with you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a Participant in the Plan.

Overpayments
An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to you or to someone else (for example, a healthcare provider) on your or your Covered Dependent's behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a healthcare provider, the Plan may request a refund of the overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, but the amounts withheld may not reduce your pay below the applicable state minimum wage law to the extent permitted by law.

Forfeitures
Failure to claim any amount or cash any check that becomes payable to you or is paid on your behalf under this Plan within two years after such amount first becomes payable, will result in such amount being forfeited. Such amounts shall cease to be a liability of the Plan, provided due and proper care has been exercised by the Plan Administrator in attempting to make such payment.

Entire Representation
This document, along with any summary, schedule of benefits, or Booklet describing any Benefit Plan, together are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).

Acceptance and Cooperation
If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents that may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law
The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction
Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural.

Non-Assignment Of Rights
No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Errors
An error cannot give a benefit to you if you are not actually entitled to the benefit.

Severability
The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

STATEMENT OF ERISA RIGHTS

As a Participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan And Benefits

- Examine, without charge, at the Plan Administrator's office and at other locations specified by the Company all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, if any, and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, copies of the latest annual report (Form 5500 Series), if any, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself, spouse, or Covered Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Covered Dependents may have to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions By Plan Fiduciaries
In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan Participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your Claim for a welfare benefit is denied 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 above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them in 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 benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan'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.

Assistance With Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator you should contact the nearest Area Office of the EBSA, 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, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

EXECUTION

IN WITNESS WHEREOF, Dow Corning Corporation has caused this amendment and restatement of the Plan, captioned "Dow Corning Corporation Health and Welfare Benefits Plan For Retirees and Inactive Employees," to be executed by its duly authorized officer this 4TH day of DECEMBER, 2015, to be effective January 1, 2015.

DOW CORNING CORPORATION

By: _____

Its: CHIEF HUMAN RESOURCES OFFICER

INDEX OF DEFINED TERMS

PARTICIPATING AFFILIATES CHART

Hemlock Semiconductor Corporation ("HSC")
Site Services, Inc. ("CSI")
Dow Corning STI, Inc. ("STI")
Dow Corning Compound Semiconductor Solutions, LLC ("DCCSS")
Multibase, Inc.
Dow Corning Alabama, Inc.

BENEFIT PLAN INFORMATION CHART

Benefit Plan	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
• **BCBS of MI** *PPO* *HDHP/HSA*	**Self-Funded**	**Blue Cross Blue Shield of Michigan**
	Filing Medical Claims • Urgent Care, Pre-Service, Concurrent Care and Post-Service Claims	BCBS of Michigan National Customer Service Ctr P.O. Box 5124 Southfield, MI 48034-5124 (866) 491-3083 www.bcbsm.com
	Filing an Appeal of a Denied Medical Claim • First level review	Send your request to the address found in the top right corner of your Explanation of Benefits or call (866) 491-3083
	• Second level review	Dow Corning Corporation Appeals Board Attn: Plan Administrator P.O. Box 994, Mail HRSC Midland, MI 48686-0995
	Filing Prescription Drug Claims • Urgent Care, Pre-Service, Concurrent Care and Post-Service Claims	Express Scripts P.O. Box 14711 Lexington, KY 40512 (866) 491-3083 www.express-scripts.com
	Filing an Appeal of a Denied Prescription Drug Claim • First level review	Express Scripts 1 Express Way St. Louis, MO 63121 (866) 491-3083 www.express-scripts.com
	• Second level review	Dow Corning Corporation Appeals Board Attn: Plan Administrator P.O. Box 994, Mail HRSC Midland, MI 48686-0995

Benefit Plan	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
• **Aon Retiree Health Exchange** *Medicare coverage*	**Insured**	**Refer to individual insurance policy purchased through Aon**
Dental Plan	**Self-funded** Filing a Claim • Urgent Care, Pre-Service, Concurrent Care and Post-Service Claims Filing an Appeal of a Denied Claim • First level review • Second level review	**Delta Dental Plan of Michigan** Delta Dental Plan of Michigan PO Box 30416 Lansing, MI 48909 (800) 524-0149 www.deltadentalmi.com Delta Dental Plan of Michigan PO Box 30416 Lansing, MI 48909 (800) 524-0149 www.deltadentalmi.com Dow Corning Corporation Appeals Board Attn: Plan Administrator P.O. Box 994, Mail HRSC Midland, MI 48686-0995
LTD Plan	**Insured** **For individuals disabled prior to 2010:** Filing a Claim and Appeal of a Denied Claim You must submit your completed claims forms within 30 days after the elimination period (180 days of disability) **For individuals disabled in 2010 or thereafter:** Filing a Claim and Appeal of a Denied Claim You must submit your completed claims forms within 30 days after the elimination period (180 days of disability)	**Prudential Financial Insurance Company of America** Prudential Financial Insurance Company of America 290 West Mount Pleasant Ave. Livingston, NJ 07039 **Aetna Life Insurance Company** Aetna Life Insurance Company P.O. Box 14560 Lexington, KY 40512-4560 (877) 832-8241 Fax: (866) 667-1987

Benefit Plan	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Life Insurance Plan • Basic Life (all participants) • Optional Life (Retirees under age 65 and Inactive Employees only) • Dependent Life (Retirees under age 65 only) AD&D (Retirees under age 65 only)	**Insured** Filing a Claim and Appeal of a Denied Claim	**Minnesota Life Insurance Company** Minnesota Life Insurance Company Group Insurance 400 Robert Street North St. Paul MN 55101-2098 (866) 293-6047