Summary Plan Description for:

Medical, Dental, Vision and Reimbursement Account Benefits

APPLICABLE TO ELIGIBLE ACTIVE EMPLOYEES

Effective January 1, 2021

This Summary Plan Description ("SPD") supersedes all prior SPDs. Copies of updated SPDs (including this SPD) are available online at www.dowbenefits.com. You may also request a copy, free of charge, from HR Solutions at (833) 693-6947 or by submitting your request through the Dow U.S. Benefits Site's Message Center at http://dowbenefits.ehr.com. Summaries of material modifications may also be published from time to time in separate documents.

Table of Contents

Section 1. ERISA Information

Summary Plan Description for
Medical, Dental, Vision and Reimbursement Account Benefits

The Medical, Dental, Vision and Reimbursement Account Benefits Program (the "Program") is comprised of a number of legal plans (referred to individually as the "Plan" or collectively as the "Plans") that are governed by the Employee Retirement Income Security Act of 1974 ("ERISA") and identified in the Appendices to this SPD. This section provides important legal and administrative information. Information that is specific to each Plan may be found in the Appendices to this SPD.

If you have any questions about any of the information contained in this SPD, contact the Plan Administrator.

Type of Plan	The Plans are ERISA welfare benefit plans providing certain medical, dental, vision, employee assistance program ("EAP") benefits to certain eligible employees. The Plans also provide health care flexible spending account and dependent care flexible spending account benefits. These are collectively referred to in this SPD as the "Benefit Programs."
Type of Plan Administration	The Benefit Programs of the Plans may be fully-insured by the Insurers listed in the Appendices pursuant to group insurance contracts entered into between The Dow Chemical Company (the "Company" or "Dow") and the Insurers or self-funded by the Company. For fully-insured benefits, premiums are paid to the Insurers from the Company's general assets. The Insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-funded benefits, the Company is responsible for paying benefit claims from its general assets.
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641
Employer Identification Number	38-1285128
Plan Administrator	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641

	Attn: U.S. Health and Insurance Plan Manager (877) 623-8079 The Plan Administrator is your primary source of information about the Plans. The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plans, to determine eligibility for benefits under the Plans, and to resolve any disputes that arise under the Plans. Benefits under the Plans will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.
HR Solutions	The Dow Chemical Company HR Solutions P.O. Box 2169 Midland, MI 48674 (833) 693-6947
Eligibility Claims Administrator	*To submit a Claim for an Eligibility Determination:* Dow HR Solutions North America Benefits P.O. Box 2169 Midland, MI 48641 Attn: Initial Claims Reviewer (Claim for Eligibility Determination) *To appeal a denied Claim for an Eligibility Determination:* Dow HR Solutions North America Benefits P.O. Box 2169 Midland, MI 48641 Attn: U.S. Benefits Plan Manager (Appeal for Eligibility Determination)
Agent for Service of Legal Process	The Dow Chemical Company 2030 Dow Center Midland, MI 48674 Attn: General Counsel Legal process on the Plan may also be served on the Plan Administrator.
COBRA Administrator	Willis Towers Watson BenefitConnect|COBRA DEPT: COBRA PO Box 981915

	El Paso, TX 79998 1-877-29-COBRA (26272) https://cobra.ehr.com
Plan Year	The Plan Year is January 1 to December 31.

Section 2. Introduction

This is the SPD for certain health and welfare benefits offered under the Program, including medical, dental, vision, EAP, health care flexible spending account and dependent care flexible spending account benefits. The provisions of this SPD apply only to active employees. This SPD supplements each certificate of insurance (or evidence of coverage) produced by the Insurer for each of the Benefit Programs (the "Certificates") and the current annual enrollment materials. The Certificates and current annual enrollment materials are incorporated into this SPD for the Program.

The Plans are governed by the plan documents for the Program, which are the legal instruments under which the Program is operated. If there is a conflict between this SPD and the Plan document, the Plan document shall govern. You may request a copy of the Plan document from the Plan Administrator.

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

Capitalized words in this SPD are defined either in the Plan document, or in *Section 28. Definitions of Terms*, or in the applicable Appendix for the specific Plan.

The words "they", "them", and "their" shall include all genders, unless the context clearly indicates to the contrary. Article and Section headings are included for convenience of reference and are not intended to add to, or subtract from, the terms of the Plan.

Section 3. Eligibility

3.1 Eligibility for Employees and Certain Disabled Individuals

Employee Eligibility

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

- Are an active, Regular, Full-Time or Less-Than-Full-Time Salaried U.S. Employee of a Participating Employer;
- Are an active, Regular, Full-Time Bargained-for U.S. Employee of a Participating Employer whose Bargaining Unit and Participating Employer have agreed to the Program. However, if the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Program, then the terms of such collective bargaining agreement shall govern; or
- Are an Employee who is retained by a Participating Employer pursuant to a written contract or agreement that states that you are eligible to participate in one of the Plans.

Additional rules regarding eligibility for a Plan are reflected in the Appendix for the Plan.

Benefit Protected Leave of Absence

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

Severance Agreement

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

3.2 Dependent Eligibility

Eligible Employees may enroll their eligible Dependents in certain Benefit Programs. A Dependent may be either your Spouse, your Domestic Partner, or an eligible Dependent Child. You must be enrolled in order to enroll a Spouse/Domestic Partner or Dependent Child. If you enroll your Spouse/Domestic Partner or Dependent Child, you will be required to provide their Social Security numbers to the Plan.

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

Spouse and Domestic Partner Exclusions

Your Spouse or Domestic Partner is not eligible for coverage under the medical Plan if they are:

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

When your Spouse or Domestic Partner is no longer eligible for coverage because of one of the above events, contact Dow HR Solutions within 90 days.

Working or Retired Spouse/Domestic Partner Rule

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

If your Spouse/Domestic Partner has coverage through their employer, as described in the preceding paragraph, and you enroll your Spouse/Domestic Partner in the medical Plans the following rules apply:

- If your Spouse/Domestic Partner has enrolled in coverage offered by their employer (or former employer), the payment of benefits under the Plan will be secondary to your Spouse/Domestic Partner's coverage through their employer (or former employer) under the Plan's coordination of benefits rules.
- If your Spouse/Domestic Partner fails to enroll in the coverage available through their own employer (or former employer):
    1. You will be charged 102% of the full cost of coverage (i.e., without any employer subsidy, if applicable) retroactive to the first day that your Spouse/Domestic Partner was enrolled in the Plan and failed to enroll in their own employer's coverage.

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

2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through their employer), the Program may cancel coverage for you and/or your Spouse/Domestic Partner retroactive to the first day that your Spouse/Domestic Partner failed to enroll in the employer's coverage. If coverage is cancelled, you will be required to reimburse the Plan for claims paid during the coverage period. See *Section 24. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Spouse/Domestic Partner were not eligible for coverage.

3. If you pay 102% of the full cost of coverage but you do not provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through their employer by the date determined by the Plan Administrator, coverage will terminate as of the date that the Program learns that your Spouse/Domestic Partner failed to enroll in the employer coverage.

4. If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide proof that your Spouse/Domestic Partner has since enrolled in the appropriate coverage through their employer, your Spouse/Domestic Partner will remain covered under the applicable medical Plan for the Plan Year.

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

There is no requirement for your Spouse/Domestic Partner to enroll your Dependent Child(ren) in your Spouse/Domestic Partner's coverage in order for you to cover them as Dependents under the medical Plans. If you decide to enroll your eligible Dependent Child(ren) in both the medical Plan and your Spouse/Domestic Partner's employer's group health coverage, benefits for the Dependent(s) will be coordinated between the two plans.

Waiving Coverage — Working Spouse/Domestic Partner

You should consider carefully whether it is advantageous to enroll your Spouse/Domestic Partner as a Dependent under the medical Plans if the group health coverage offered by their employer is as comprehensive or better than the medical Plans'. Any medical Plan in which you enroll your Spouse/Domestic Partner would be secondary to your Spouse/Domestic Partner's medical plan under the Dow coordination of benefits rules, as explained in *Working or Retired Spouse/Domestic Partner Rule*, above. You may choose to waive coverage for your Spouse/Domestic Partner under a medical Plan in order to save premium dollars. If you waive coverage under a medical Plan, then no coordination of benefits will occur.

Dependent Child(ren)

For purposes of the medical, dental, vision and EAP Benefit Programs, a child is eligible for coverage if the child is:

- your birth or legally adopted child; or
- your Spouse's or Domestic Partner's natural or adopted child; or
- a child for whom you or your Spouse/Domestic Partner have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently legally relinquished all of their parental rights in a court of law.

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

Dependent Child(ren) Exclusions

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

- *Reaches age 26*. Coverage ends at the end of the month in which the child turns age 26. Children age 26 or older are not eligible, unless, prior to age 26, the child is incapable of self-sustaining employment because of a physical or mental disability and is covered under the Plan on the day prior to reaching age 26. The disabled child must be principally dependent upon you for support. Proof of the child's initial and continuing dependency and disability must be provided to the Plan prior to age 26 in order for coverage to continue. You must make any contribution required by the Plan to continue coverage for your child. Once coverage is terminated, it cannot be reinstated. Contact HR Solutions for more information; or
- *Is covered as a Dependent under a Dow-sponsored or UCC-sponsored medical plan*. All eligible children in a family must be covered by the same parent. (Exceptions may be made as necessary in stepchild situations.)

When your child is no longer eligible for Dependent coverage because of one of the above events, you may be eligible to make a new enrollment within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs. For information about rights your child may have for continuation of coverage under the Program as provided by the federal COBRA law, see Section *10.2 COBRA Continuation Coverage*. Note: In order for your Dependent to receive COBRA continuation coverage, you must provide notice that your child is no longer an eligible Dependent within 60 days after your Dependent becomes ineligible.

Eligibility through a Qualified Medical Child Support Order

A child who does not qualify as a "Dependent Child" above may still be eligible for coverage if an eligible Employee has a qualified medical child support order ("QMCSO") for that child. A QMCSO is a court order that meets the Program's requirements to provide a child the right to be covered under one of the Plans offered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Program. You may obtain a free copy of the Program's QMCSO procedures, which explain how the Program determines whether a court order meets the Program's requirements, by requesting a copy from the Plan Administrator.

3.3 Eligibility Determinations of Claims Administrator Are Final and Binding

The Eligibility Claims Administrator determines your and your dependents eligibility for coverage under the Program. The Eligibility Claims Administrator is a fiduciary of the Program and has full discretion to interpret provisions of the SPD and the Plan document and to make findings of fact. Interpretations and eligibility determinations by the Eligibility Claims Administrator are final and binding. To file a Claim for an Eligibility Determination, see *Section 25. Claims Procedures*.

Section 4. Enrollment

4.1 Levels of Participation

The levels of participation available are described in the applicable Appendix and in the annual enrollment materials.

4.2 Enrolling at the Beginning of Employment

You may enroll in Program coverage on the Dow U.S. Benefits Site or by calling HR Solutions within 90 days of your date of hire.

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

If you do not enroll within 90 days of your date of hire, you will not have coverage, and you will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules. See *Section 5. Mid-Year Election Changes*.

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

If you are enrolling your Spouse/Domestic Partner and/or child(ren), you must provide proof of their eligibility within 90 days of your date of hire or the applicable annual enrollment period. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan.

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

If your Spouse is already enrolled in the Plan, you may not dis-enroll your Spouse in anticipation of a divorce. You are required to continue coverage for your Spouse and pay the applicable premium. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), when your legal separation or divorce is final, your Spouse has a right to continue coverage under the Plan at 102% of the full cost of coverage for a certain period of time. See *Section 10.2 COBRA Continuation Coverage* for more information about COBRA coverage.

4.4 Enrolling During Annual Enrollment

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

Default Enrollment

If you fail to enroll or affirmatively waive coverage under the Plan during the time period specified in the annual enrollment materials, your current Plan elections (excluding any flexible spending account or dependent care flexible spending account elections) may be automatically carried forward for the upcoming Plan Year, assuming you remain eligible for the coverage in which you are enrolled. However, each year, you must provide acceptable proof of your compliance with the *Working or Retired Spouse/Domestic Partner Rule*.

4.5 Dual Dow or UCC Coverage

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

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

4.6 Change of Elections to Prevent Discrimination

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

Section 5. Mid-Year Election Changes

In general, you pay for coverage under the Program with premiums that are pre-tax dollars through the Dow Flexible Spending Plan, a plan intended to qualify under Section 125 of the Code as a "cafeteria plan." You may only change your medical coverage level during annual enrollment, or if you have a special enrollment event or a "change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan).

Generally, you may not enroll in the Plans outside of the enrollment periods described in Section 4 and pay premiums on a pre-tax basis unless you meet the requirements of this Section 5.

Because of IRS rules, Domestic Partner coverage and coverage for children of a Domestic Partner who are not your tax dependents are generally paid for with post-tax dollars. The Program administers change in status events and the consistency rules the same way with respect to Domestic Partners as Spouses, regardless of the post-tax treatment by IRS, to the extent that such administration does not jeopardize the tax qualified status of the Program.

This section of the SPD describes special enrollment events, the definition of "change in status" and the consistency rules, and exceptions to these rules, as well as the documentation required and deadlines for making a mid-year election change.

5.1 Special Enrollment Provisions

You may be eligible to enroll in the Program outside of annual enrollment if one of the following special enrollment events occurs:

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

In order to enroll in the Program because of a special enrollment event described above, you must provide proof of the event in accordance with *Section 5.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *Section 5.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 5.7 Deadline to Enroll for Mid-Year Changes*.

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to notify the Plan following a special enrollment event, have been extended. The relief provides that any special enrollment notification deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

5.2 Change in Status

A "change in status" includes the following events:

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

5.3 Consistency Rules

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

1. The change in status must ***result*** in you, your Spouse/Domestic Partner or Dependent Child ***gaining or losing*** eligibility for coverage under either the Program or the parallel plan of your Spouse/Domestic Partner or Dependent Child's employer.

2. The election change to a Plan must ***correspond with*** that gain or loss of coverage.

3. For these purposes, the Plan reserves the right to determine what changes are "consistent" under IRS rules.

5.4 Exceptions to the Change in Status and Consistency Rules

You may change your coverage levels mid-year without having met the change in status and consistency rule requirements only under the following circumstances:

- ***Court Orders*** — You may change your election mid-year if a court order resulting from a divorce, annulment, or change in legal custody (including a Qualified Medical Child Support Order), requires a change in your Program election.
- ***Entitlement to Medicare or Medicaid*** — If you, your Spouse/Domestic Partner or Dependent are enrolled in the Program and become entitled to coverage (*i.e.*, enrolled) under Medicare or Medicaid mid-year (other than for coverage consisting

solely for distribution of pediatric vaccines), you may cancel your Program coverage.

- ***Significant Cost or Coverage Changes*** — If your Spouse/Domestic Partner is covered by their employer's plan, which allows them to change their benefit plan election because of a significant change in cost or coverage under the employer's plan, such change in your Spouse/Domestic Partner's election will allow you to change your Dow election. If your Spouse/Domestic Partner's employer's enrollment period is different from Dow's, your Spouse/Domestic Partner's election under their employer's plan may constitute a significant coverage change allowing you to change your Dow election.
- ***Special Enrollment Rights*** — You may change your Program election mid-year if you meet the special enrollment requirements addressed in *Section 5.1 Special Enrollment Provisions*.

5.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated change you are permitted to make. Any change is subject to meeting the Dependent eligibility rules and the eligibility rules for the relevant coverage option, as applicable.

Event	Permissible Change
Gain a Dependent • Birth • Adoption • Marriage • Domestic Partnership	You may enroll, you may increase your level of participation (*e.g.*, Employee Only to Employee plus Spouse or Employee plus Family), or you may change to a different coverage option (e.g., from Low Deducible to High Deductible or an HMO).
Lose a Dependent • Divorce • Death • Dependent loses eligibility • Termination of Domestic Partnership	You may decrease your level of participation (e.g., Employee plus Spouse to Employee Only). You may not change to a different coverage option (e.g., from Low Deducible to High Deductible or an HMO).
Spouse/Domestic Partner loses medical coverage elsewhere	You may enroll, increase your level of participation (e.g., Employee Only to Employee plus Spouse or Employee plus Family), or change to a different coverage option (e.g., from Low Deducible to High Deductible or an HMO).

Event	Permissible Change
Move out of HMO service area	You may change to a different coverage option if you were enrolled in an HMO and move out of the HMO's service area. You may not change your level of participation (e.g., Employee Only to Employee plus Spouse or Employee plus Family).
Move into an HMO service area	You may enroll in or change to an HMO for which you become eligible as a result of moving. You may not otherwise switch your coverage option (e.g., from Low Deducible to High Deductible, or vice versa) or change your level of participation (e.g., Employee Only to Employee plus Spouse or Employee plus Family).

5.6 Documentation of Eligibility Required to Make Election Change

Documentation is required to show proof of eligibility to make an election change and/or to show proof of Dependent eligibility. Required documentation may include birth certificates, passports, Marriage certificates, Domestic Partner signed statements, Social Security numbers, evidence of loss of Spouse/Domestic Partner or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Program reserves the right to request proof of eligibility at any time.

As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan.

Dropping or Adding a Domestic Partner

The Program will cease to recognize a Domestic Partnership as of the date stated on a valid "Termination of Domestic Partner Relationship" form (or other applicable form) filed with the Plan Administrator. After you file this form with the Plan Administrator, you must wait at least 12 months before you may add a new Domestic Partner as your Dependent. At that time, you must file a new Statement of Domestic Partner Relationship for the new Domestic Partner.

5.7 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of the annual enrollment period, you must submit the required proof of eligibility and request enrollment within 90 days of the change in status or special

enrollment event (or within 180 days for geographic relocation under the Participating Employer's relocation policy) in order to avoid being charged 102% of the full cost of coverage.

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

- For the birth of a child, the date of birth.
- For the adoption of a child, the earlier of the date of adoption or date of placement for adoption.
- For a court order, the date specified in the court order.
- In all other cases:
  - If the Plan Administrator receives your enrollment request within 31 days of the change in status or special enrollment event, the effective date of the mid-year election change will be the date of the event.
  - If the Plan Administrator receives your enrollment request on day 32 through 90 after the change in status or special enrollment event, the effective date of the mid-year election change will be the Plan Administrator's processing date.

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to notify the Plan following a special enrollment event, have been extended. The relief provides that any special enrollment notification deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

Section 6. Premiums

6.1 Failure to Pay Required Premiums

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

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

The Plan reserves the right to require you to pre-pay premiums in order to receive coverage. In addition, the provisions of *Section 24. Payment of Unauthorized Benefits*, may apply if benefits

were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

6.2 Excess Premium Payments

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

6.3 Premiums During a Benefits Protected Leave of Absence

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

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

1. With after-tax dollars, by sending monthly payments to the Plan Administrator by the due date established by the Plan Administrator.

2. With pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation.

3. The Employer may fund coverage during the leave and withhold "catch up" amounts upon your return.

4. Under another arrangement agreed upon between you and the Plan Administrator.

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

For more details on benefits continuation during an approved leave of absence, please refer to the Workday KnowledgeBase article on benefits during leaves of absence, which is incorporated into the Plan and this SPD by reference.

Section 7. Survivor Benefits

7.1 General Rule

In general, a surviving Spouse/Domestic Partner of an active Employee is eligible for 36 months of COBRA coverage if they were covered under a Plan at the time of death. See *Section 10.2 COBRA Continuation Coverage*.

7.2 Exceptions to the General Rule for Medical Coverage

As explained below, special rules apply for certain participants in certain Dow-sponsored pension plans. You or your surviving Spouse/Domestic Partner may obtain a copy of an applicable retiree medical SPD from Dow HR Solutions. The retiree medical SPD provides eligibility and cost information about the coverage available to survivors. If your surviving Spouse/Domestic Partner is enrolled for coverage under an applicable retiree medical plan, your surviving Dependent Child(ren), including your biological child in utero, also may be covered if they meet the Dependent eligibility requirements. If your surviving Spouse/Domestic Partner works full time or is retired, they must enroll your child(ren) in any employer-sponsored health coverage for which they are eligible (including from a former employer).

Vested Participants in the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan

If you were hired prior to January 1, 2008, and were a vested participant in the Dow Employees' Pension Plan or Union Carbide Employees' Pension Plan, your surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow or UCC retiree medical summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center at 1-800-344-0661.

Vested Participants of the Rohm and Haas Company Retirement Plan

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

Employees of Dow Corning Corporation Hired before January 1, 2017

If you were hired by Dow Coming Corporation before January 1, 2017, your surviving Spouse/Domestic Partner might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow retiree medical summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center.

7.3 Surviving Children without Surviving Spouse/Domestic Partner

If there is no surviving Spouse/Domestic Partner, your surviving children who were eligible for coverage at the time of your death will be able to receive continued coverage for up to 36 months. This coverage meets the requirements of, and runs concurrently with, the coverage required under COBRA. Dow subsidizes the COBRA premiums for the first 12 months. Your surviving Dependent Children will be eligible for coverage under the Plan with premiums applicable to active Employees for up to one year after the date of your death. Thereafter, if they were covered for the first 12 months and paid the required premiums, they will be offered the remaining 24 months of coverage at COBRA rates — 102% of the full cost to insure. *In order to be covered, they must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

Surviving children of a Dow Corning Corporation employee hired before January 1, 2017 might be eligible for coverage under a Dow retiree medical program. Refer to the applicable Dow retiree medical summary plan description for eligibility requirements for surviving children, or call the Retiree Service Center.

Section 8. Notices Required by Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996, and other federal legislation require notice of the following:

8.1 Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that the medical Program provide Participants notice that certain reconstructive surgery after a mastectomy is covered. While each Plan provided coverage for such surgery prior to the enactment of this law, this paragraph provides notice of your rights under the law. If a Participant receives benefits covered under the Plan in connection with a mastectomy and elects breast reconstruction, the Plan will provide coverage for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, you may contact the Plan Administrator.

8.2 Maternity Stays

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Program or Plan or an insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

8.3 Information Exchanged by the Program's Business Associates

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

As a Participant, you will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact your Insurer or the Plan Administrator.

8.4 Children's Health Insurance Program (CHIP) Notice

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) but are unable to afford the premiums, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but who also have access to health insurance through their employer. If you or your children are NOT eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, or if you think you might be eligible for Medicaid or CHIP, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW (543-7669), or go to www.insurekidsnow.gov to find out if premium assistance is available. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

8.5 Military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage for up to 24 months as long as you give the Company advance notice (with

certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from the Employer, does not exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both the Company and your contributions) necessary to cover a similarly-situated employee who does not go on military leave.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave or you do not elect to continue coverage during your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months from the commencement of the military leave.

8.6 Mental Health Parity

The medical Program may not, under federal law, impose any limits or restrictions on mental health coverage that are less favorable than the other hospital/medical/surgical coverages.

8.7 Continuation of Coverage During FMLA Leave

If the Company grants you an approved FMLA leave, your coverage will continue during your approved leave as long as you continue to pay your required contributions, if any. FMLA continuation coverage will end on the earliest date on which: (1) the Company determines your approved FMLA leave is ended, (2) you are otherwise no longer eligible for coverage, as permitted by applicable laws and regulations, or (3) you fail to make any required contribution. For additional information about FMLA leaves, contact the Plan Administrator.

Section 9. Fraud Against the Program

If you intentionally misrepresent information to the Program or Plan, knowingly withhold relevant information from the Program or Plan, or deceive or mislead the Program or Plan, the Plan Administrator may (1) terminate your participation in the Plan, either retroactively to the date deemed appropriate by the Plan Administrator, or prospectively; (2) require you to reimburse the Plan for amounts it paid to you or your Dependent(s), including all costs of collection such as attorneys' fees and court costs; and/or (3) prohibit you from enrolling in the Program or Plan. In addition, your employer may terminate your employment, pursue civil and/or criminal action against you, or take other legal action. If you or your Dependent(s) are terminated from eligibility under any benefit plan sponsored by Dow or a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 10. Ending Coverage

10.1 When Coverage Ends

Except as otherwise provided in this Section 10.1, a Participant's coverage ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Participant elects not to participate for the Plan Year
- The Participant's death
- Termination of the Plan or Program
- Failure to pay the required premiums
- Failure to reimburse the Program or Plan for claims paid by the Program or Plan that, under the terms of the Program or Plan, you or your Dependent are required to reimburse the Program or Plan
- Failure to comply with the terms and conditions of the Program or the Plans
- Providing false or misleading information to the Program or the Plans

If your Dependent is no longer eligible or dies, update your enrollment information on the Dow U.S. Benefits Site or by contacting HR Solutions as soon as possible, but no later than 90 days of the loss of eligibility. The loss of coverage for your Dependent will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

Generally, your coverage terminates on the date you cease to be eligible to participate in the Program. However, if you cease to be eligible to participate in the Program due to a voluntary termination of employment and you are eligible for either The Dow Chemical Company Retiree Medical Program, the Union Carbide Corporation Retiree Medical Care Program, or the Rohm and Haas Retiree Medical Care Program, your coverage terminates on the last day of the month in which you terminate employment. Generally, your Dependent's coverage under the Plan will terminate when your coverage terminates.

10.2 COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of coverage under the Program that may become available to you and to other members of your family who are covered under the Program when you or they would otherwise lose group health coverage because of a life event known as a "qualifying event." (Note: The Dependent Care Flexible Spending Account is not eligible for COBRA continuation coverage, and special rules may apply for purposes of the Health Care Flexible Spending Account.)

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

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

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

What is a qualifying event?

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Child(ren) could become qualified beneficiaries if coverage under the Program is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

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

1. Your Spouse dies;

2. Your Spouse's hours of employment are reduced;

3. Your Spouse's employment ends for any reason other than their gross misconduct (only applicable to Spouses who are active Employees working for a Participating Employer);

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

5. You become divorced or legally separated from your Spouse.

Although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners with comparable protection to Spouses for the qualifying events described above.

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

1. The parent-Employee dies;

2. The parent-Employee's hours of employment are reduced (only applicable to active Employees working for a Participating Employer);

3. The parent-Employee's employment ends for any reason other than their gross misconduct (only applicable to active Employees working for a Participating Employer);

4. The parent-Employee enrolls in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

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

When is COBRA Coverage Available?

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

IMPORTANT: You Must Give Notice of Some Qualifying Events

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

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

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

If the qualifying event is a Dependent Child's loss of eligibility for coverage under a Plan, you must complete a Change in Status form that may be obtained from the Dow U.S. Benefits Site or by requesting one from HR Solutions. In addition, you must complete a Dependent Qualifying

Event letter, which may be obtained from the Plan Administrator. You must return these forms to the Plan Administrator within 60 days of the Dependent losing eligibility for coverage.

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

How is COBRA Coverage Provided?

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

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

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to return the COBRA election form, have been extended. The relief provides that any COBRA election deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

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

(1) *Medicare Extension for Spouse and Dependent Children*

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

enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

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

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

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

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

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

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

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

How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage.

First Payment of Continuation Coverage

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

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to pay required COBRA premiums, have been extended. The relief provides that any COBRA premium payment deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

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

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. You must make your payment by the due date or within the grace period. Periodic payments for continuation coverage should be

sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to pay required COBRA premiums, have been extended. The relief provides that any COBRA premium payment deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

Grace Periods for Periodic Payments

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

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to pay required COBRA premiums, have been extended. The relief provides that any COBRA premium payment deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate Recipients under QMCSOs

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment

period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Keep the Program Informed of Address Changes

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

Section 11. Subrogation

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

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

11.1 The Program's Entitlement to Reimbursement

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

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

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

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

First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person acknowledges that the Program's recovery rights are a first priority claim against all Third Parties and are to be paid to the Program before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Program is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, ***even if such payment to the Program will result in a recovery to the Covered Person that is insufficient to make them whole*** (*i.e.*, the "make whole" doctrine will not apply).

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

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

Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys' fees.

11.2 Your Responsibilities

The Covered Person is required to fully cooperate with the Program's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and their agents shall provide all information requested by the Program, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Program may reasonably request. The rights described in this Section 12 are assigned to the Program without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Program an assignment and other instruments that may be used to facilitate securing the rights of the Program. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

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

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

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

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

11.3 Jurisdiction

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

Section 12. Your Legal Rights Under ERISA

As a Participant in the Program, you are entitled to certain rights and protections under ERISA. This law requires that all Program Participants must be able to:

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

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for

Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Program fiduciaries misuse the Program's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. For more information regarding enforcing your rights in court, see *Section 17. Litigation and Class Action Lawsuits*.

Assistance with your Questions: If you have any questions about the information in this SPD or an eligibility for coverage question, you should contact the Plan Administrator. If you have a question about the benefits covered, or the terms and conditions for receiving benefits, network providers, etc., you should contact the Insurer. For the contact information for the Plan Administrator , see *Section 1. ERISA Information*. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Section 13. Plan Administrator's Discretion

The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan document (including this SPD), make determinations, make findings of fact, adopt rules and procedures applicable to matters they are authorized to decide and delegate certain authority and responsibilities that they have with respect to the Plans. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan document and *Section 25. Claims Procedures*.

Section 14. Plan Document

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

Section 15. No Government Guarantee of Welfare Benefits

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

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

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

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

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

Section 17. Litigation and Class Action Lawsuits

17.1 Litigation

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

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

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the Program or to clarify your right to future benefits under the terms of the Program, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Program first repudiated its alleged obligation to provide such benefits;

2. in the case of a claim or action to enforce an alleged right under the Program (other than a claim or action to recover benefits), the date the Program first denied your request to exercise such right; or

3. in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

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

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

The Applicable Limitations Period replaces and supersedes any limitations period that ends at a later time that otherwise might be deemed applicable under any state or federal law. The Applicable Limitations Period does not extend any limitations period under state or federal law.

17.2 Class Action Lawsuits

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

If any putative class action is filed in a jurisdiction other than one of those described above, or if any non-class action filed in such a jurisdiction is subsequently amended or altered to include class action allegations, then the Program, all parties to such action that are related to the Program (such as a plan fiduciary, administrator or party in interest), and all alleged Participants must take all necessary steps to have the action removed to, transferred to, or re-filed in one of the jurisdictions described above. This forum selection provision is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations. This provision does not waive the requirement to exhaust administrative remedies before initiating litigation.

Section 18. Incompetent and Deceased Participants

If the Plan Administrator determines that you or your Dependent is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan, the Plan Administrator may make benefit payments to the court-appointed legal guardian for you or your Dependent, to an individual who has become the legal guardian for you or your Dependent by operation of state law, or to another individual whom the Plan Administrator determines is the appropriate person to receive such benefits on behalf of you or your Dependent. Payments due to deceased Participant from claims made under a Plan shall be made to the Participant’s estate.

Section 19. Privilege

If the Company or a Participating Employer (or a person or entity acting on behalf of the Company or a Participating Employer) or an Administrator or other Plan fiduciary (an "Advisee") engages attorneys, accountants, actuaries, consultants, and other service providers (an "Advisor") to advise them on issues related to the Plan or the Advisee's responsibilities under the Plan:

- the Advisor's client is the Advisee and not any Employee, Participant, Dependent, beneficiary, claimant, or other person;
- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and
- no Employee, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or their Advisors with respect to whom a privilege applies, unless mandated by a court order.

Section 20. Waivers

A term, condition, or provision of the Program shall not be waived unless the purported waiver is in writing signed by the Plan Administrator. A written waiver shall operate only as the specific term, condition, or provision waived and shall remain in effect only for the period specifically stated in the waiver.

Section 21. Providing Notice to Administrator

No notice, election or communication in connection with the Program that you, a Dependent or other person makes or submits will be effective unless duly executed and filed with the appropriate Administrator (including any of its representatives, agents, or delegates) in the form and manner required by the appropriate Administrator.

Section 22. Funding

Dow shares the premium costs for certain benefits under the Program with Employees. Employee contributions are generally made through payroll deduction. Benefits are paid from the Company's general assets.

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

Section 23. Uncashed Checks

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

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

Section 24. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program or Plan were provided to, or on behalf of, a Participant or other person (for example,

because benefits were paid even though the individual did not meet the Program eligibility requirements):

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

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

Section 25. Claims Procedures

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

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

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation.

25.1 Deadline to File a Claim

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

Notwithstanding the foregoing, effective January 1, 2022, all Claims must be filed within 12 months of the date the service was rendered.

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to file a claim for benefits, have been extended. The relief provides that any claim filing deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

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

The Program has more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you appeal an initial determination, the appellate decision is made by the Appeals Administrator. Each of the Claims Administrators is a named fiduciary of the Program with respect to the types of Claims that it processes.

- *Claims for Plan Benefits*. The Initial Claims Reviewer and the Appeals Administrator are provided in the applicable Appendix.
- *Claims for an Eligibility Determination*. The Initial Claims Reviewer and the Appeals Administrators are provided in *Section 1. ERISA Information*.

Authority of Claims Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Program under Section 502 of ERISA in federal court, provided you complete the claims procedures described in this *Section 25. Claims Procedures* (or the Claims Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *Section 17.1 Litigation* for the deadline for filing a lawsuit.

25.3 An Authorized Representative May Act on Your Behalf

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

25.4 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

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

- The name of the Employee (or former Employee), and the name of the person (Employee, Dependent, Survivor, as applicable) who is requesting the eligibility determination;
- The name of the Plan for which the eligibility determination is being requested; and
- If the eligibility determination is being requested for the Employee's dependent:
  - a description of the relationship of the dependent to the Employee (e.g., Spouse/Domestic Partner, Dependent Child, etc.); and
  - documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility Determination must be sent to the Initial Claims Reviewer at the address provided in *Section 1. ERISA Information*.

Initial Determination

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

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

Appealing the Initial Determination

If the Initial Claims Reviewer has denied your Claim, you may appeal the decision. If you appeal the Initial Claims Reviewer's decision, you must do so in writing within 60 days of receipt of the Initial Claims Reviewer's determination, assuming that there are no extenuating circumstances, as

determined by the Appeals Administrator. Your written appeal must include the following information:

- The name of the Employee;
- The name of the Dependent, if the Dependent is the person who is appealing the Administrator's decision;
- The name of the Plan;
- Reference to the initial determination; and
- An explanation of the reason why you are appealing the initial determination.

Notwithstanding the foregoing, due to the COVID-19 pandemic, certain important deadlines, including the deadline to file an appeal, have been extended. The relief provides that any appeal filing deadline that would have otherwise occurred on or after March 1, 2020, will be extended until the earlier of (a) one year following the original deadline, or (b) the expiration of the COVID-19 National Emergency period plus 60 days.

Appeals of Claims for an Eligibility Determination should be sent to the address provided in *Section 1. ERISA Information*. You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You also may request that the Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

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

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

The Appeals Administrator will notify you in writing of its decision. If your claim is denied, in full or part, the written notification of the decision will state (1) the reason(s) for the denial; (2) refer to the specific provision(s) in the Plan Document on which the denial is based; (3) that you are entitled to receive upon request and free of charge reasonable access to and copies of all

documents, records, and other information relevant to your claim (as determined by the Claims Administrator under applicable federal regulations); and (4) that you have a right to bring a civil action under section 502 of ERISA.

25.5 How to File a Claim for Plan Benefits

The Insurers and third party administrators of the Plan are responsible for evaluating all benefit claims under the Plans. The Insurers and third party administrators will decide all claims in accordance with their reasonable claims procedures, as required by ERISA and applicable state laws. The Insurers and third party administrators have the full power to interpret and apply the terms of the Plans as they relate to the benefits provided under the applicable insurance contract, group policy or certificate of insurance.

To obtain benefits from an Insurer or third party administrator under a particular Plan, you must follow the claims procedures under the applicable insurance contract, group policy or certificate of insurance and described in the applicable certificate, policy or booklet. The Insurers and third party administrators have the right to seek independent medical advice and to require you to provide other evidence as they deem necessary to decide your claims and appeals.

If the Insurer or third party administrator denies your claim, in whole or in part, you will receive a notice of the denial and an explanation of how you may appeal the decision, as required by ERISA. Except as may be otherwise required by law, the final decision of the Insurer or third party administrator will be binding on all parties. You must exhaust all required appeals prior to bringing any civil suit under ERISA.

Refer to the applicable certificate, policy or booklet for a description of the claims and appeals procedures under a particular Benefit Program or Plan.

Section 26. Tax Consequences of Coverage and Benefits

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

Section 27. No Assignment of Benefits

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

Section 28. Definitions of Terms

The following are some of the defined terms of the Program. Additional terms are defined in the Plan document and the Appendices. A copy of the Plan document is available upon request.

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

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

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

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

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

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

Company
The Dow Chemical Company.

Dependent
An Employee's Spouse, Domestic Partner, or Dependent Child(ren), or a child to whom a Qualified Medical Child Support Order applies.

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

- Your birth or legally adopted child; or
- Your Spouse's or Domestic Partner's natural or adopted child; or
- A child for whom you or your Spouse/Domestic Partner have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently "legally relinquished all of their parental rights" in a court of law.

In addition to meeting the above requirements, in order to be eligible for coverage, the Dependent Child must not be excluded for one of the reasons described in *Dependent Child(ren) Exclusions* under Section 3.2.

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

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

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

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

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

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

Employee
A person who:

- is employed by a Participating Employer to perform personal services in an employer-employee relationship;

- receives a payment for services performed for the Participating Employer directly from a Participating Employer's U.S. Payroll Department;
- if not a U.S. citizen or a U.S. resident alien, is Localized in the U.S.; and
- if on international assignment, is either a U.S. citizen or Localized in the U.S.

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

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement between the Participating Employer and another business, such as a leasing organization;

2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;

3. an individual whom is classified or treated as an independent contractor; or

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

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

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

High Deductible Medical Plan
The High Deductible Medical Plan, which is a plan within the Program.

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

HIPAA
The Health Insurance Portability and Accountability Act.

HMO
Health Maintenance Organization.

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

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

Low Deductible Medical Plan
The Low Deductible Medical Plan, which is a plan within the Program.

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

Married or Marriage
A legal marriage between two individuals for federal tax purposes. The Program does not recognize common law marriages except that:

1. If an Employee was a participant of a plan of The Dow Chemical Company Medical Care Program before November 1, 1993, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a Dow Medical Plan before November 1, 1993, then such common law Spouse is deemed under the Program to be Married to the Employee;

2. Effective January 1, 1996, the Program recognizes a marriage that meets the requirement of Texas Family Code Annotated section 2.402; and

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

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

Participant
An Employee, Dependent or such other individual who meets the eligibility criteria of the Program, elects to participate in the Program, and remains eligible for benefits under the Program.

Participating Employer
The Company or one of its subsidiaries that has been authorized by the Company to participate in the Program. "Participating Employers" and "Dow" have the same meaning and are used interchangeably. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

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

Rohm and Haas (or "ROH")
Rohm and Haas Company and certain of its subsidiaries.

Salaried
Not represented by a collective bargaining unit.

Spouse
A person who is Married to an Employee (or other individual eligible for coverage under Section 3.1 of this SPD).

UCC or Union Carbide
Union Carbide Corporation and certain of its subsidiaries.

Urgent Care Claim
Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Section 29. For More Information

For more information regarding the provisions in this SPD, please contact Dow HR Solutions using the contact information in *Section 1. ERISA Information*.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Program. However, it is not all-inclusive and it is not intended to take the place of the Program's legal documents. The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and any underlying Plan) at any time in its sole discretion.

The Plan document can be made available for your review upon written request to the Plan Administrator. The SPD and the Program shall not confer employment rights upon any person.

No person shall be entitled by virtue of the SPD or the Program to become or to remain in the employ of the Company and nothing in the SPD or the Program shall restrict the right of the Company to terminate the employment of any eligible employee or other person at any time.

Appendix A. Medical Plan Information

Medical Plan 1

Former SPD Name:	The Dow Chemical Company Medical Care Program's Active Employee Low Deductible Medical Plan and High Deductible Medical Plan
Legal Plan Name:	The Dow Chemical Company Medical Care Program
Legal Plan Number:	Plan 501
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits: Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106 (800) 7-DOW-DOW ((800) 736-9369) To appeal a denied Claim for Plan Benefits: Aetna, Inc. Attn: National Accounts CRT P.O. Box 14463 Lexington, KY 40512

Levels of Participation

The levels of participation available are:

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

You must be enrolled in order to enroll your Dependent. In general, you may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the Low Deductible Medical Plan, your Dependent may not be enrolled in the High Deductible Medical Plan or in an HMO or insured plan.

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

Your Contribution

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

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

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

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

Please refer to the Description of Plan Benefits for Low Deductible Medical Plan and the Description of Plan Benefits for High Deductible Medical Plan for any remaining coverage questions.

Medical Plan 2

Former SPD Name:	The Dow Chemical Company Medical Care Program's and The Dow Chemical Company Retiree Medical Care Program's Self-Funded HMO Plans
Legal Plan Name:	The Dow Chemical Company Medical Care Program
Legal Plan Number:	Plan 501
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits, contact the applicable Self-Funded HMO administrator: Blue Care Network PO Box 68767 Grand Rapids, MI 49516-8767 (800) 662-6667 www.miben.com CIGNA HealthCare PO Box 182223 Chattanooga, TN 37422 (800) 244-6224 www.myCIGNA.com Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601 (800) 448-6262 www.humana.com To appeal a denied Claim for Plan Benefits, contact the applicable administrator: Blue Care Network Grievance and Appeals Unit Mail Code C248 P.O. Box 284 Southfield, MI 48086 CIGNA Appeals Unit P.O. Box 188011 Chattanooga, TN 37422 (800) 244-6224 Humana Grievance and Appeals

P.O. Box 14546
Lexington, KY 40512-4546

Self-Funded HMO Plan Availability

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

- Blue Care Network is available in Michigan.
- CIGNA is available in Ohio, Texas, Illinois, New Jersey, North Carolina, or South Carolina.
- Humana is available in Louisiana.

If you move and thereby cease to be eligible for your Self-Funded HMO Plan, you may change your enrollment.

Levels of Participation

The levels of participation available are:

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

You must be enrolled in this Plan in order to enroll your Dependent Spouse/Domestic Partner or Dependent Child in this Plan. You may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the Blue Care Network Self-Funded HMO Plan under the Program, your Dependent may not be enrolled in a different Self-Funded HMO Plan or in an Insured HMO Plan or either the Low Deductible or High Deductible Medical Plans. Exceptions apply. See Section *Dependent Eligibility*, above.

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

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

If you move during the Plan Year and remain eligible to participate in the Program, but your Self-Funded HMO Plan is not offered at your new location, you may switch your coverage to Dow-sponsored medical coverage that is available at the new location and for which you are eligible. If you want to continue receiving health coverage under a Dow-sponsored plan after you move, you must notify HR Solutions within 90 days of your transfer (or 180 days for geographic location

under the Participating Employer's relocation policy). Your ability to switch coverage is subject to the rules in Section Mid-Year Election Changes.

Your Contribution

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

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

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

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

Please refer to the Description of Plan Benefits for the Blue Care Network HMO Plan, the CIGNA HMO Plan, or the Humana HMO Plan for any remaining coverage questions.

Appendix B. Dental Plan Information

Dental Plan 1

Former SPD Name:	Delta Dental Premier Basic Plan, Delta Dental PPO High Plan, Participating in The Dow Chemical Company Dental Assistance Program
Legal Plan Name:	The Dow Chemical Company Dental Assistance Program
Legal Plan Number:	Plan 503
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits: Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085 To appeal a denied Claim for Plan Benefits: Dental Director Delta Dental P.O. Box 30416 Lansing, MI 48909-7916

Eligibility for Employees and Certain Disabled Individuals

Rohm and Haas Long Term Disability Participants

If you were a Rohm and Haas Company Employee who was approved for and is receiving disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for dental coverage under the Program if your qualifying disability was incurred prior to January 1, 2010. You remain eligible for Program coverage until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. You must pay the same premiums active Employees of Dow pay for comparable coverage. If you are described in this section, you are treated as an active "Employee" for purposes of this SPD.

LTD Participants (other than DCC Employees)

If you were not a DCC Employee and have been approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), you are eligible for coverage under the Dental Plan 1 under the following circumstances:

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

If you were hired by Dow or Union Carbide on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), or you have less than ten (10) years of Service, you are eligible for up to either 12 months or 24 months of dental coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have one (1) year of Service or more.

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

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

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

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

If you are receiving benefit payments from both LTD and the Union Carbide Employees' Pension Plan, you are not eligible for dental coverage under the Program.

If you are described in this section regarding LTD Participants, you are treated as an "Employee" for purposes of this SPD.

Certain Texas T&P Disability Plan Recipients

If you are a Texas Operations Bargained-for Employee who has been declared by the Company's Medical Director to be "Totally and Permanently Disabled" as defined under Company's Texas Operations Hourly Total & Permanent Disability Plan ("Texas T & P") and you meet and continue to meet all of the requirements of Texas T & P for receiving benefits under that plan, you are eligible for dental coverage under the Program. However, if you receive benefits under the Dow Employees' Pension Plan pursuant to a voluntary election to commence pension benefits, you are not eligible. Currently, if you were not covered as a Dependent under the Program through your Spouse at the time you were approved for disability benefits, the Company will pay the premiums for dental coverage.

If you are eligible under the above paragraph, you are treated as an active "Employee" for purposes of this SPD.

DCC Long Term Disability Participants

Certain disabled individuals of DCC are eligible for coverage under the Program. In general, to the extent that you are eligible for coverage under the Program as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as an Employee of Dow, unless otherwise stated.

Disabled on or after January 1, 2017

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

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

Disabled before January 1, 2017

If you are a DCC LTD Participant:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for dental coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).
- Dow will communicate to you annually the contribution amount you are required to pay in order to participate.

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

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

If you are described in this section regarding DCC LTD Participants, you are treated as an "Employee" for purposes of this SPD.

Levels of Participation

The levels of participation available are:

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

You must be enrolled in order to enroll your Dependent. You may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the Basic plan, your Dependent may not be enrolled in PPO High or a DMO.

Once you are enrolled in a Plan, you may view your claims information, eligibility status, benefit levels and annual maximums by visiting the Delta Dental Consumer Toolkit at www.deltadentalmi.com. You will need to register and create a user name and password in order to access the Consumer Toolkit. During registration, you will be prompted for your Member ID Number, which is the Dow Employee's Number with three preceding zeroes (e.g., 000123456). From the Consumer Toolkit, you can also print an ID card showing your group number and the address for your Dentist to submit claims. An ID card is not required with Delta Dental, but it may be helpful for you and your Dependents.

Your Contribution

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

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

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

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

Please refer to the Description of Plan Benefits for your Plan for any remaining coverage questions.

Dental Plan 2

Former SPD Name:	Dental Maintenance Organizations (DMOs) and Insured Dental Plans Participating in The Dow Chemical Company Insured Health Program
Legal Plan Name:	TDCC Insured Health Program
Legal Plan Number:	Plan 601
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits, contact the applicable DMO or insurer. See the materials provided by the DMO or insured dental plan. The Dow Chemical Company Health-Coverage Compliance PO Box 5807 Hopkins, MN 55343

About DMOs and Insured Plans

How DMOs Operate

DMOs are a form of prepaid dental assistance designed to help keep you and your family's teeth healthy by encouraging regular checkups and early detection of dental problems. Some DMOs provide services in a DMO-owned facility, perhaps with satellite facilities, staffed by their own dentists, specialists and other health care professionals. Others offer services through independent dental offices or through dentists and specialists under contract with the DMO.

The intent of a DMO is to maintain the dental health of its members while ensuring dental coverage when needed. The DMO provides services for emergencies and dental conditions, but the emphasis is on preventive dentistry. In addition, DMOs try to reduce dental expenses by conducting, when possible under one roof, routine dental maintenance services that are most commonly used by members.

Generally, when you join a DMO, you select a Primary Care Dentist ("PCD") from the DMO staff or on contract with the DMO. You agree to use the DMO's facilities and staff, or those under contract to the DMO, instead of obtaining services from dentists, specialists or facilities not affiliated with the DMO.

Your PCD will be responsible for managing dental care for you and your family. However, the DMO dentist can, on occasion, refer you to a non-affiliated provider. Services obtained from any dentist or facility not affiliated with the DMO will not be covered by the DMO unless authorized by a DMO dentist, or provided under emergency conditions.

A DMO concentrates its resources in a specific geographic area, sometimes a county or an area defined by residential zip codes. Most DMOs do not provide coverage outside their service area other than for emergencies, life-threatening conditions, or referrals by the PCD.

DMOs should not refuse to provide services or coverage because of a labor dispute involving employees of the DMO. Generally, you will not be billed directly by the DMO for any dental services – except for charges such as copayments for services only partially covered by the DMO.

Any disagreement between you and the DMO becomes a matter to which you and the DMO should respond. For example, if you disagree with the DMO over a settlement of a Claim, or have any questions concerning a physician referral, you should follow the review and appeals procedures of that DMO. Any charge not paid by the DMO becomes your responsibility – not Dow's. If a DMO fails to pay a charge directly to a health care provider or fails to provide coverage for an expense you feel should be covered, the disagreement should be settled between you and the DMO.

In general, if your employment with Dow terminates, you may convert to an individual policy with your DMO. Also, under certain circumstances, you may continue coverage for you and your Dependents for a limited time under the rules established in the Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). For details about COBRA, see Section COBRA Continuation Coverage, or contact Dow HR Solutions at (877) 623-8079. For details about converting your DMO coverage to an individual policy, contact your DMO at the contact information listed in the materials it provides you.

Dow and DMOs

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

Information that Your DMO Should Provide You

Each DMO will supply you, upon written request, written materials concerning:

- the nature of services provided to the DMO's members;
- conditions pertaining to eligibility to receive such services in addition to general eligibility conditions for the Program described in this SPD Wrapper;
- the circumstances under which services can be denied;
- the procedures to be followed in obtaining such services and the procedures available for the review of the Claims for Benefits that are denied in whole or in part.

Plan Availability

Besides meeting the eligibility criteria described in this SPD Wrapper, in order to participate in a particular Plan, you must be located where the Plan is available. If you move and thereby cease to

be eligible for your Plan, you may change your enrollment. See Section If You Move out of the DMO Covered Location during the Plan Year below.

Eligibility for Employees and Certain Disabled Individuals

Rohm and Haas Long Term Disability Participants

If you were a Rohm and Haas Company Employee who was approved for and is receiving disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for dental coverage under the Program if your qualifying disability was incurred prior to January 1, 2010. You remain eligible for Program coverage until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. You must pay the same premiums active Employees of Dow pay for comparable coverage. If you are described in this section, you are treated as an active "Employee" for purposes of this SPD.

LTD Participants (other than DCC Employees)

If you were not a DCC Employee and have been approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), you are eligible for Plan coverage under the Program under the following circumstances:

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

If you were hired by Dow or Union Carbide on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), or you have less than ten (10) years of Service, you are eligible for up to either 12 months or 24 months of dental coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have one (1) year of Service or more.

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

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

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

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

If you are receiving benefit payments from both LTD and the Union Carbide Employees' Pension Plan, you are not eligible for dental coverage under the Program.

If you are described in this section regarding LTD Participants, you are treated as an "Employee" for purposes of this SPD.

Certain Texas T&P Disability Plan Recipients

If you are a Texas Operations Bargained-for Employee who has been declared by the Company's Medical Director to be "Totally and Permanently Disabled" as defined under Company's Texas Operations Hourly Total & Permanent Disability Plan ("Texas T & P") and you meet and continue to meet all of the requirements of Texas T & P for receiving benefits under that plan, you are eligible for dental coverage under the Program. However, if you receive benefits under the Dow Employees' Pension Plan pursuant to a voluntary election to commence pension benefits, you are not eligible. Currently, if you were not covered as a Dependent under the Program through your Spouse at the time you were approved for disability benefits, the Company will pay the premiums for dental coverage.

If you are eligible under the above paragraph, you are treated as an active "Employee" for purposes of this SPD.

DCC Long Term Disability Participants

Certain disabled individuals of DCC are eligible for coverage under the Program. In general, to the extent that you are eligible for coverage under the Program as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as an Employee of Dow, unless otherwise stated.

Disabled on or after January 1, 2017

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

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

Disabled before January 1, 2017

If you are a DCC LTD Participant:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for dental coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).
- Dow will communicate to you annually the contribution amount you are required to pay in order to participate.

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

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

If you are described in this section regarding DCC LTD Participants, you are treated as an "Employee" for purposes of this SPD.

Levels of Participation

The levels of participation available are:

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

You must be enrolled in order to enroll your Dependent. You may enroll your Dependent only in the same Plan in which you are enrolled. For example, if you are enrolled in the Aetna DMO, your Dependent may not be enrolled in the Cigna DMO as well as the Basic plan or PPO High.

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

If You move out of the DMO Covered Location during the Plan Year

If you move during the Plan Year and remain eligible to participate in the Program, but your Plan is not offered at your new location, you may switch your coverage to a DMO that is available under the Program at the new location or switch to a self-insured plan offered under The Dow Chemical Company Dental Assistance Program. If you want to continue receiving dental coverage under a Dow-sponsored plan after you move, you must notify HR Solutions within 90 days of your move (180 days for geographic relocation under the Participating Employer's relocation policy).

Reminder: If you make new enrollment elections, be certain to enroll and confirm your dental provider participates in your chosen Network before services are performed.

Your Contribution

You and Dow share the premium costs for your dental coverage. Your contributions are paid through payroll deductions. For your portion of the monthly premium, refer to the materials provided during the annual enrollment period. The amount you pay is the difference between the total cost of DMO/insured plan coverage and Dow's contribution.

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

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

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

Appendix C. Vision Plan Information

Vision Plan

Former SPD Name:	The Dow Chemical Company Insured Health Program's Vision Plan
Legal Plan Name:	TDCC Insured Health Program
Legal Plan Number:	Plan 601
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits, contact: VSP 3333 Quality Drive, Rancho Cordova, CA 95670-7985 1-800-877-7195

About the Plan

Dow and the Plan

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

Information that VSP Should Provide You

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

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

Levels of Participation

The levels of participation available are:

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

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

You must be enrolled in the Plan in order to enroll your Dependent Spouse/Domestic Partner or Dependent Child in the Plan.

Your Contribution

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

If you are an Employee, contributions for coverage for you, your Spouse and/or your Dependent Child(ren) are deducted on a pre-tax basis through the Dow Flexible Spending Plan, a Plan intended to qualify under Section 125 of the Code as a "cafeteria plan." Because of IRS regulations, contributions for Domestic Partner coverage are deducted on a post-tax basis. Coverage for children of Domestic Partners also must generally be paid on a post-tax basis, unless the child is your dependent and cannot be claimed as a dependent on someone else's tax return, such as your Domestic Partner's tax return.

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

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

Premiums for LTD Participants

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

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

In addition, the provisions of Section 23 Payment of Unauthorized Benefits, may apply if benefits were paid to, or on behalf of, you or your Dependent(s) during a period for which you did not have coverage, including as a result of a retroactive cancellation of coverage.

Please refer to the Description of Plan Benefits for the Vision Plan for any remaining coverage questions.

Appendix D - Employee Assistance Program (EAP) Plan Information

EAP Plan 1

Former SPD Name:	The Dow Chemical Company Medical Care Program's Active Employee Low Deductible Medical Plan and High Deductible Medical Plan
Legal Plan Name:	The Dow Chemical Company Medical Care Program
Legal Plan Number:	Plan 501
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits: Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106 (800) 7-DOW-DOW ((800) 736-9369) To appeal a denied Claim for Plan Benefits: Aetna, Inc. Attn: National Accounts CRT P.O. Box 14463 Lexington, KY 40512
EAP Contact:	Aetna Employee Assistance Program 151 Farmington Ave RSAA Hartford, CT 06156

Employee Assistance Plan

If you are an Employee enrolled in either of the Plans, you are eligible for free Employee Assistance Plan ("EAP") services. The EAP provides professional and confidential counseling on emotional, social and mental health issues for employees and dependents experiencing personal difficulties. Participation is voluntary and typically self-referred. EAP support is available 24-hours per day, 7-days per week. The EAP provides up to six visits to an EAP counselor for assessment and referral or short-term counseling. The types of issues supported by the EAP include:

- Interpersonal relationships
- Anxiety/stress
- Depression/mental health issues
- Teen/Parent relationships
- Separation/Divorce

- Financial/legal problems
- Grief/loss
- Anger management/violence

When EAP services are not medical in nature, they are called "EAP Direct Services." The part of the EAP that provides EAP Direct Services is not part of any HMO plan or insured plan offered under the Program. EAP Direct Services are not offered under Dow ERISA Plan #501 or Dow ERISA Plan #601, or any other Dow-sponsored ERISA plan. Sometimes, during EAP counseling sessions, a limited amount of mental health counseling occurs, which is medical in nature. The part of the EAP that provides these limited mental health services is a component of each of the HMOs or insured plans under the Program called "Medical EAP."

The EAP is administered by Aetna:

Aetna Employee Assistance Program
151 Farmington Ave RSAA
Hartford, CT 06156

Contact a local EAP provider,

By phone at 1-888-488-4488 (TTY: 711), or

Online at ResourcesForLiving.com (username and password: MYDOWEAP)

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

Am I Still Eligible for the EAP If I Am Not Enrolled In the Plan?

Yes. If you decided not to enroll in the Low Deductible or the High Deductible Plans under the Program, you are still eligible for free EAP benefits if you are an Employee, and:

- You are enrolled in another Dow employee medical plan, Medical EAP benefits are provided by the plan in which you are enrolled.
- If you are not enrolled in any Dow employee medical plan, Medical EAP benefits are provided under the Low Deductible Medical Plan.

If you die while you are eligible for EAP services, your surviving Spouse/Domestic Partner and Dependent Children will be eligible for EAP services for up to one year after the date of your death.

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

Please refer to the Description of Plan Benefits for Low Deductible Medical Plan and the Description of Plan Benefits for High Deductible Medical Plan for any remaining coverage questions.

EAP Plan 2

Former SPD Name:

The Dow Chemical Company Medical Care Program's and The Dow Chemical Company Retiree Medical Care Program's Self-Funded HMO Plans

Legal Plan Name:

The Dow Chemical Company Medical Care Program

Legal Plan Number:

Plan 501

Claims Administrators for Claims for Plan Benefits:

To submit a Claim for Plan Benefits, contact the applicable Self-Funded HMO administrator:

Blue Care Network
PO Box 68767
Grand Rapids, MI 49516-8767
(800) 662-6667
Fax: (866) 637-4972

CIGNA HealthCare
PO Box 182223
Chattanooga, TN 37422
(800) 244-6224
www.myCIGNA.com

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601
(800) 448-6262
www.humana.com

To appeal a denied Claim for Plan Benefits, contact the applicable administrator:

Appeals and Grievance Unit
Blue Care Network
P.O. Box 284
Southfield, MI 48086-5043
Fax: 866-522-7345
CIGNA Appeals Unit
P.O. Box 188011
Chattanooga, TN 37422
(800) 244-6224

Humana Grievance and Appeals
P.O. Box 14546

Lexington, KY 40512-4546

EAP Contact: Aetna Employee Assistance Program
151 Farmington Ave RSAA
Hartford, CT 06156

Employee Assistance Plan

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

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

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

When EAP services are not medical in nature, they are called "EAP Direct Services." The part of the EAP that provides EAP Direct Services is not part of any Plan. EAP Direct Services are not offered under Dow ERISA Plan #501 or Dow ERISA Plan #601, or any other Dow-sponsored ERISA plan. Sometimes, during EAP counseling sessions, a limited amount of mental health counseling occurs, which is medical in nature. The part of the EAP that provides these limited mental health services is a component of each of the Plans called "Medical EAP."

The EAP is administered by Aetna:

- Aetna Employee Assistance Program
  151 Farmington Ave RSAA
  Hartford, CT 06156

Contact a local EAP provider,

By phone at 1-888-488-4488 (TTY: 711), or

Online at ResourcesForLiving.com (username and password: MYDOWEAP)While Medical EAP provides limited mental health benefits at no cost to you, if you are enrolled in a Plan, the Plan also provides more extensive mental health coverage; that coverage and the costs of coverage are described in the applicable Description of Plan Benefits.

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

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

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

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

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

Self-Funded HMO Plan Availability

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

- Blue Care Network is available in Michigan.
- CIGNA is available in Ohio, Texas, Illinois, New Jersey, North Carolina, or South Carolina.
- Humana is available in Louisiana.

If you move and thereby cease to be eligible for your Self-Funded HMO Plan, you may change your enrollment.

Please refer to the Description of Plan Benefits for the Blue Care Network HMO Plan, the CIGNA HMO Plan, or the Humana HMO Plan for any remaining coverage questions.

Appendix E. Health Care Flexible Spending Account Plan Information / Limited Purpose Flexible Spending Account Plan Information

Health Care FSA / Limited Purpose FSA Plan

Former SPD Name:	The Dow Chemical Company Health Care Flexible Spending Account Plan
Legal Plan Name:	Health Care Flexible Spending Account
Legal Plan Number:	Plan 508
Claims Administrators for Claims for Plan Benefits:	To submit a claim for reimbursement (a Claim for Plan Benefits): PayFlex Systems USA, Inc. P.O. Box 2495 Omaha, NE 68103 To appeal a denied Claim for Plan Benefits: PayFlex Systems USA, Inc. P.O. Box 2495 Omaha, NE 68103

The Health Care Flexible Spending Account Plan

Overview

The Plan is designed to help you save tax dollars. It allows you to set aside part of your salary in pre-tax dollars for you to draw on throughout the year to meet certain expenses. Part of your salary can be directed into a Health Care Flexible Spending Account ("HCFSA") or Limited Use Flexible Spending Account ("Limited Use FSA"). Based on your needs, and those of your family, you may consider participating in this Plan.

The Plan has been designed according to current tax law. Changes in the law may affect provisions of the Plan.

Purpose and Highlights of the Plan

The Plan allows you to use pre-tax dollars to pay for eligible medical, dental and vision expenses incurred by you, your Spouse, or anyone you claim as a Dependent on your federal income tax return. The Plan reimburses you for expenses that are not covered by your medical, dental or vision plans or by any other source. When expenses are incurred, you submit them to the Claims Administrator for reimbursement. In general:

- You are eligible to make pre-tax deposits for health care expenses if you are an active, Regular, Full-Time or Less-Than-Full-Time Salaried Employee or an active, Regular, Full-Time Bargained-for Employee whose collective bargaining agreement provides for your participation.
- You may enroll during the annual enrollment period, or within 90 days of beginning work or experiencing a qualifying change in status (180 days for geographic transfer) through the Dow U.S. Benefits Site or by calling HR Solutions.
- You may make deposits to a HCFSA or Limited Use FSA (your "Account") totaling $100 to $2,750 each year for reimbursement of qualified health care expenses. The maximum amount will be adjusted for inflation each tax year.
- You should determine the amount of your pre-tax deposits by estimating your health care expenses for the year.
- If you participate, you are reimbursed from your Account throughout the year when you submit expenses to the Claims Administrator.

Enrollment

The Accounts in Which You May Enroll

Two types of Accounts are available under the Plan: the HCFSA and the Limited Use FSA. Only the Limited Use FSA is compatible with a Health Savings Account ("HSA"), meaning that if you contribute to an HSA you may not contribute to the HCFSA. Accordingly, the following default rules will apply:

- If you are not enrolled in the High Deductible Medical Plan but are enrolled in other Dow medical coverage and you elect to participate in this Plan, you will be enrolled in the HCFSA.
- If you enroll in the High Deductible Medical Plan and you elect to participate in the Plan, you will be enrolled in the Limited Use FSA (so that you can also simultaneously participate in an HSA), and as long as you are otherwise eligible. If you want to be enrolled in HCFSA, contact HR Solutions at (877) 623-8079 before the enrollment deadline passes.
- If you are not enrolled in any Dow medical coverage and you elect to participate in this Plan, you will be enrolled in the HCFSA. If you want to be enrolled in the Limited Use FSA, contact HR Solutions at (877) 623-8079 before the enrollment deadline passes.

You may use amounts deposited to either the HCFSA or the Limited Use FSA to reimburse eligible expenses (described below under Reimbursement of Qualified Expenses). However, if you are enrolled in the Limited Use FSA, you cannot use your Account to reimburse medical and pharmacy expenses before you meet your deductible under the High Deductible Medical Plan (or other high deductible health plan).

Deposits To Your Account

Payroll Deductions

Your contributions to your Account are made through pre-tax payroll deductions as authorized by your enrollment. The deductions are made before you pay federal, Social Security and, usually, state and local income taxes. You must determine your total deposits for the calendar year when you enroll. For more details, please refer to the latest annual enrollment information.

If you are on a leave of absence approved by the Participating Employer that allows you to continue participating in the Plan, the Plan Administrator has the full discretion to make special administrative arrangements as are necessary, such as suspending your contributions on a temporary basis during the leave of absence, and requiring you to contribute make-up deposits when you return to work, or any other arrangements that are permitted under applicable law that the Plan Administrator deems appropriate.

Note: Pre-tax deposits may reduce the Social Security benefit you are eligible for from the government because the pre-tax deposits are not included in your earnings used to calculate your Social Security benefit.

Deposit Amounts

You may elect to deposit from $100 to $2,750 each year. If your Spouse participates in the Plan as an eligible Employee or in a health flexible spending arrangement offered by their employer, you may each contribute up to $2,750 to each of your accounts. The maximum amount will be adjusted for inflation each tax year.

Changing Deposit Amount

Your deposits into the Plan are made with pre-tax dollars through the Dow Flexible Spending Plan, a plan intended to qualify under Section 125 of the Internal Revenue Code (the "Code") as a "cafeteria plan." You may change the amount of your deposits only during annual enrollment, or if you have a "qualifying change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan).

This section of the SPD describes the definition of "qualifying change in status," the "consistency rules," and the exceptions to these rules, as well as documentation required to change deposit amounts, deadlines for making these changes, and the Plan's authority to reduce benefit elections of certain Participants.

Any change or termination of your election for your Account may not result in reducing your election to an amount that is less than the amount by which your Account is debited for qualified expenses incurred during the period prior to the effective date of your changed or terminated election. If your new, changed, or terminated election does not meet these requirements, it will be automatically adjusted so that your new election will equal the amount by which your Account has been debited for qualified expenses as of the effective date of the new election.

Reimbursement of Qualified Expenses

In general, you may use your Account to reimburse the same types of expenses that qualify as deductions for medical expenses on your federal income tax return. To be eligible for reimbursement from your Account, the expenses must not be eligible for reimbursement by your medical or dental plans or by any other source. Expenses must be incurred on or after the date of your enrollment in the Plan.

Your expenses will be reimbursable after the service was incurred, not when you pay for the service. For example, for orthodontic services, your expenses will be eligible to be reimbursed when the service is incurred, even if you pay for all of the services upfront when the services begin.

You may request reimbursement for eligible expenses incurred by your Spouse and Dependents even if they do not have Dow medical or dental plan coverage, as long as the expenses are not eligible for reimbursement from a medical or dental plan or any other source.

If you are enrolled in the Limited Use FSA, you may use it to reimburse qualified dental, vision, and preventive care expenses incurred any time on or after you enroll in the Plan; however, you may not use your Account to reimburse medical or prescription drug expenses (other than qualified preventive care expenses) before you meet your deductible under the High Deductible Medical Plan (or other high deductible health plan). Once you meet your deductible under the High Deductible Medical Plan (or other high deductible health plan), you may use your Limited Use FSA to reimburse any expenses that may be reimbursed under the HCFSA, including medical or prescription drug expenses that are not for preventive care.

Examples of eligible medical, dental, and vision expenses include:

- Routine physicals that are not covered by your medical plan.
- Eye examinations, glasses, and contact lenses and supplies.
- Hearing aids.
- Medical and dental plan deductibles and co-payments.
- Expenses that exceed medical and dental plan limits.
- The medical portion of nursing home expenses.
- Over-the-counter medications.
- Menstrual products.
- Personal Protective Equipment.

Examples of expenses that are not eligible include:

- Insurance premiums.
- Health-related home improvements such as swimming pools or air conditioners.
- Health club dues and/or memberships.

- Cosmetic surgery or procedures that are not medically necessary including hair removal or replacement.

Internal Revenue Service Publication No. 969 includes additional examples of qualified and unqualified expenses. Please contact PayFlex if you have any questions regarding expenses that are eligible for reimbursement under the Plan.

If You Leave Dow

If you leave Dow, retire, or transfer to an employer that does not participate in the Plan, you may use money already deposited for expenses incurred for services rendered prior to the date you left Dow, retired, or transferred to an ineligible employee group. Your Claim for reimbursement must be received by the Claims Administrator on or before April 30 after the end of the Plan Year. Please see *HCFSA Claims Procedures* for more information about how to submit Claims.

In order to keep coverage through the end of the Plan Year, you may request to deduct a lump-sum from your last paycheck, your accrued vacation payment, or severance pay using pre-tax dollars, equal to an amount sufficient to fulfill the remainder of your annual election. Deductions from accrued vacation payments and severance pay are permissible. Your request must be made and submitted to Payroll prior to the last paycheck, vacation payment or severance payment sufficient to cover the remainder of your annual election being issued, and you must waive your COBRA rights under the Plan. Your request will not be processed if the amount remaining to be paid to you is less than the remainder of your annual election. Your Claim for reimbursement must be received by the Claims Administrator on or before April 30 of the next Plan Year to file claims for expenses incurred for services rendered through the end of the current Plan Year.

Under COBRA, if you have not used all of the money you have contributed to your Account as of the date you leave Dow, you may elect to continue to contribute the remaining balance due using post-tax dollars at 102% of your contribution amounts. Your Claim for reimbursement must be received by the Claims Administrator on or before April 30 of the next plan year to file claims for expenses incurred for services rendered through the end of the plan year. Notwithstanding the foregoing, if you elect COBRA Continuation Coverage and you have a balance remaining at the end of the plan year, you will be eligible to carry over that remaining balance in accordance with the provisions outlined below under “Carryover”. For more information, see COBRA Continuation Coverage.

Automatic Roll-over Feature for Network Pharmacy Expenses - For Participants in Dow Low Deductible Medical Plan

If you enroll in the Low Deductible Medical Plan or a Delta Dental of Michigan Dental Plan, and you elect the "automatic roll-over" feature during annual enrollment, PayFlex and Delta Dental will automatically submit for reimbursement under the Plans the portion of any claims that are not covered by the Low Deductible Medical Plan or Delta Dental Plan that you incur under the Low Deductible Medical Plan or Delta Dental Plan. You benefit by not having to file a Claim for Reimbursement under the Plan and by having your reimbursement automatically sent to you or directly deposited into your bank account. In addition, amounts payable toward your deductible under the Low Deductible Medical Plan will be automatically deducted from your Account.

The automatic roll-over feature will be triggered only if you have a positive Account balance. The automatic roll-over feature is not available to you if:

- You or your covered Dependent have coverage through another medical plan and you coordinate coverage with that plan;
- You cover a Domestic Partner under your medical plan;
- Your Spouse works for Dow, and you are covered under your Spouse's Dow medical plan; or
- You are not enrolled in the Low Deductible Medical Plan (e.g., if you are enrolled in the High Deductible Medical Plan).

Carryover

If there are unused funds available in your HCFSA as of the end of the year, you are permitted to carry over up to a maximum of $500 from one plan year into the next. Those funds are in addition to your elected amount for the subsequent plan year. For instance, if you elected to have $1,000 in your HCFSA each year for Plan Year 1 and Plan Year 2, and you had $250 left in your HCFSA as of the end of Plan Year 1, your new available account balance as of January 1 of Plan Year 2 is $1,250 ($250 carryover plus $1,000 newly elected funds).

For the 2020 and 2021 Plan Years only, you are permitted to carry over any amount of unused funds as of the end of each Plan Year to be used in the subsequent Plan Year.

Effect of HCFSA on Health Savings Accounts

If you have a remaining balance in your HCFSA (not a Limited Use FSA) at the end of a Plan Year, and you elected during annual enrollment to participate in the High Deductible Medical Plan for the upcoming Plan Year, your remaining balance in your HCFSA will be converted into a Limited Use FSA effective as of January 1 of the following year. As a result of this conversion, you should be able to contribute to an HSA beginning January 1, assuming you are not otherwise enrolled in disqualifying coverage (e.g., a general purpose health care flexible spending account through your spouse’s employer).

Forfeitures

Any balance from the previous year that remains in your Account after the deadline for incurring and submitting claims must be forfeited. The Plan may have "experience gains" when the premiums (i.e., deposits) it receives from individual Participants exceeds their reimbursements for the Plan Year. Experience gains may be retained by the Company or used in any of the following ways, at the Plan Administrator's discretion:

- Defray reasonable administrative costs of the Plan.
- Increase coverage amount to Participants.
- Provide Participants with experience gains in the form of cash.

If the Plan Administrator decides to use experience gains to increase the coverage amount to Participants, the maximum annual amount that a Participant may elect to receive under the Plan may be increased by the amount of such experience gain allocated to such Participant.

Note that if the Plan Administrator distributes the experience gains to the Participants by increasing coverage or distributing cash, the specific Participants whose excess premiums contributed to such experience gains in any given Plan Year may not necessarily be the ones who will receive a distribution of the experience gains. The individuals who will receive the experience gains will be the Employees who are enrolled in the Plan during the Plan Year(s) in which the Plan Administrator has determined that a distribution of experience gains will be made. Such experience gains will be allocated to the Participants on a reasonable and uniform basis. Federal law prohibits basing the amount of experience gain to be distributed to each Participant on the amount forfeited by the Participant.

When determining the amount to deposit in your Account for the upcoming year, you can minimize your risk of forfeiture by reviewing your health care expenses from past years, and anticipating changes.

Each time you are reimbursed from your Account, you may receive a withdrawal statement that shows recent deposits and your current balance.

COBRA Continuation Coverage

When is COBRA Coverage Available?

A Participant has no right to COBRA continuation coverage if, as of the date of the qualifying event, the Participant has spent the entire balance of their Account.

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

Generally, COBRA Continuation Coverage can only extend through the end of the plan year in which your qualifying event occurs. Notwithstanding the foregoing, if you elect and remain covered under COBRA through the end of the plan year, and you have a balance remaining at the end of the plan year, you will be eligible to carry over that remaining balance into the subsequent plan year in accordance with the provisions of the section labeled “Carryover” above.

Tax Considerations

Your Account contributions reduce your taxable income, allowing you to pay taxes on a smaller amount of income each payday.

IRS federal income tax provisions allow an itemized deduction when your eligible health care expenses exceed a certain percentage of your adjusted gross income. You may wish to consult a tax advisor.

Note: You may not reimburse an expense from your Account under the Plan and claim an itemized deduction for that expense on your income taxes.

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

HCFSA Claims Procedures

Claims for Reimbursement (Claims for Plan Benefits)

For expenses covered by a medical or dental plan, you must first submit a Claim to that plan. After you receive an Explanation of Benefits ("EOB") statement showing any remaining unpaid expenses or a receipt for medical expenses for which you may not receive an EOB, such as prescription drug purchases, you may submit a Claim for reimbursement. To receive reimbursement for any expenses, you must timely submit a Claim for reimbursement. You have not timely submitted a valid Claim unless you have submitted a completed Reimbursement Request Form or online reimbursement request, in each case with all information that the Claims Administrator requires, by the deadlines described below, or unless your expense is submitted pursuant to the automatic roll-over feature.

If you are enrolled in the Low Deductible Medical Plan or a Delta Dental of Michigan Plan, which are eligible for the automatic roll-over feature, and you have elected to participate in such roll-over feature, your deductible, out-of-pocket amount and some non-covered medical expenses will be automatically sent to the Plan for processing. (Currently, the automatic rollover feature is not available when coordinating benefits with the High Deductible Medical Plan or a non-Dow medical plan.)

A Reimbursement Request Form is the document that describes the information that the Claims Administrator requires as part of a Claim. You may send a completed Reimbursement Request Form with the required supporting documentation to the address listed on the form or to the address listed below. Note: If you are covered by more than one group dental or medical plan, include both EOB statements. Be sure to keep copies of these documents for your tax records.

A Reimbursement Request Form can be obtained by calling HR Solutions at 833-MYDOWHR, or one can be printed off the Dow Benefits & Wellbeing website.

When you submit the Reimbursement Request Form, you must attach any documents required by the Claims Administrator. The Reimbursement Request Form with the required supporting documentation may be mailed or faxed to:

PayFlex Systems USA, Inc.
PO Box 4000
Richmond, KY 40476-4000

Online reimbursement requests may be submitted at www.payflex.com.

Your Claims must be received by the Claims Administrator by April 30 of the year following the year in which the expense is incurred. Expenses are "incurred" when you are provided with the medical or dental care, service, or product that gives rise to the expenses.

Appendix F. Health Savings Account Information

Health Savings Account

Former SPD Name:	N/A
Legal Plan Name:	N/A
Legal Plan Number:	N/A
Claims Administrators for Claims for Plan Benefits:	To submit a claim for reimbursement (a Claim for Plan Benefits): Call (800) 544-3716 at the time of service or visit the Net Benefits website: NetBenefits Login Page - The Dow Chemical Company (fidelity.com) [nb.fidelity.com]

If you enroll in the High Deductible Medical Plan, you may be eligible to make pre-tax contributions to a Health Savings Account (HSA). The HSA is an individually-owned bank account and is not governed by ERISA. You may only make pre-tax contributions to the HSA custodian selected by the Employer, which is currently Fidelity Investments. However, you may make post-tax contributions to the HSA on your own as well.

If you contribute more than the maximum permitted, or you make or receive HSA contributions when you are not eligible, you may be subject to excise taxes. Dow does not contribute to the HSAs of Participants in the High Deductible Medical Plan.

To make and/or receive contributions to the HSA:

- You must be enrolled in the High Deductible Medical Plan, or in VA health care
- You must not have any other medical coverage (e.g., Medicare or coverage under your Spouse's plan or a former employer's plan), unless that coverage also qualifies as "high deductible" coverage or the coverage is an excepted benefit under the federal tax laws;
- Neither you nor your Spouse may participate in a health flexible spending account (FSA) if the FSA can reimburse expenses other than dental or vision expenses before the minimum deductible determined by the IRS is satisfied. You may participate in Dow's Limited Use FSA, but not Dow's HCFSA, which are described in Appendix E; and
- You cannot be claimed as a dependent on someone else's tax return.

If you do not meet the above requirements, you can still enroll in the High Deductible Medical Plan for your medical coverage, but you will not be eligible to make HSA contributions.

Your HSA is an individual bank account in your name. This account is not maintained, sponsored, or endorsed by Dow. You can use your HSA contributions and any earnings to pay out-of-pocket medical, dental and vision expenses, referred to as "Qualified Expenses." In general, Qualified Expenses for your HSA include any medical, dental and vision expenses for you, your Spouse or

tax dependents that qualify for a medical expense deduction on your federal income taxes. (Note, however, that the same expense cannot be reimbursed from your HSA and deducted from your federal incomes taxes.) For example, Qualified Expenses generally include coinsurance, amounts that are applied to your deductible, and the cost of drugs that are prescribed for you.

If you don't use all the money in your HSA during the Plan Year, the balance can be carried over for reimbursement of Qualified Expenses in subsequent years. For more information about HSAs and how you can use your HSA contributions, see IRS Publication 969 available at www.irs.gov.

You are solely responsible for managing your HSA to ensure that contributions qualify for favorable tax treatment and that funds are used only for Qualified Expenses. HSAs are not subject to a claims process. Making or receiving contributions to an HSA when you are not eligible, or withdrawing HSA funds for expenses that are not qualified, will generally result in tax penalties. You should consult your tax advisor.

For more information about the Fidelity Investments-HSA, visit https://nb.fidelity.com/public/nb/dow/home.

Appendix G. Dependent Care Flexible Spending Account Plan Information

Dependent Care FSA Plan

Former SPD Name:	The Dow Chemical Company Dependent Care Flexible Spending Account Plan
Legal Plan Name:	N/A
Legal Plan Number:	N/A
Claims Administrators for Claims for Plan Benefits:	To submit a claim for reimbursement (a Claim for Plan Benefits): PayFlex Systems USA, Inc. P.O. Box 2495 Omaha, NE 68103 To appeal a denied Claim for Plan Benefits: PayFlex Systems USA, INC P.O. Box 2495 Omaha, NE 68103

The Dependent Care Flexible Spending Account Plan

Overview

The Plan is designed to help you save tax dollars. It allows you to set aside part of your salary in pre-tax dollars for you to draw on throughout the year to meet certain dependent care expenses. Part of your salary can be directed into the Dependent Care Flexible Spending Account. Based on your needs, and those of your family, you may consider participating in this Plan.

The Plan's reimbursements of qualified dependent care expenses are intended to be eligible for exclusion from a Participant's gross income under Section 129(a) of the Internal Revenue Code (the "Code"). The Plan document is intended to satisfy the written document requirement of Section 129(d)(1) of the Code. The Plan is not intended to be an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Changes in the law may affect provisions of the Plan. Provisions in this SPD Wrapper that reference ERISA, COBRA, HIPAA or other federal mandates that apply to group health plans or excepted benefits do not apply to the Dependent Care Flexible Spending Account.

Purpose and Highlights of the Plan

The Plan allows you to use pre-tax dollars to pay for eligible dependent care expenses incurred while you work. You determine the amount of your deposits, made through payroll deduction, to

cover estimated dependent care expenses for the year. When expenses are incurred, you submit them to the Claims Administrator for reimbursement. In general:

- You are eligible to make pre-tax deposits for dependent day care expenses if you are an active, Regular, Full-Time or Less-Than-Full-Time Salaried Employee, or an active, Regular Full-Time Bargained-for Employee whose collective bargaining agreement provides for your participation.
- You may enroll during the annual enrollment period, or within 90 days of beginning work or experiencing a change in status (180 days for geographic transfer) through the Dow U.S. Benefits Site or by calling HR Solutions.
- You may make deposits totaling $100 to $5,000 ($10,500 for 2021 only) each year per family for reimbursement of qualified dependent day care expenses if you enroll for participation. If you are married, your Spouse must also be employed or a full-time student or disabled and incapable of self-care.
- You should determine the amount of your pre-tax deposits by estimating your dependent day care expenses for the year.
- If you participate, you are reimbursed from your Account throughout the Plan Year, and through March 15 of the following year when you submit expenses. Notwithstanding the foregoing, for purposes of the 2020 and 2021 Plan Years only, your grace period for incurring expenses will extend through the end of the Plan Year following the Plan Year to which the election relates.

2021 Special Enrollment Window

For the 2021 Plan Year only, there is a special enrollment window for the DCFSA for the period of April 26 - May 7. During this window, you are permitted to enroll in coverage, drop coverage, or make changes to your elected amount regardless of whether you have experienced a qualifying life event.

Eligibility

You are eligible to participate in the Plan if your employment meets one of the classifications stated in Part A and you meet both of the requirements described in Part B.

Part A

- All active, Regular, Full-Time and Less-Than-Full-Time Salaried Employees and any such Employees who are on a medical or family leave approved by a Participating Employer are eligible, as governed by the terms of the applicable Dow leave policy.
- Except as otherwise provided in the applicable collective bargaining agreement, active, Regular, Full-Time Bargained-for Employees whose collective bargaining unit and the Participating Employer have agreed to this benefit are eligible to participate. If the terms of the collective bargaining agreement specifically address which Employees are eligible or not eligible for this Plan, then the terms of such collective bargaining agreement shall govern as to whether an Employee is eligible.

Part B

- You have a dependent who is a Qualifying Individual; and
- If you are Married, your Spouse is employed, unless they are a full-time student or disabled and incapable of self-care.

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

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by the Participating Employer such as under the Company's military leave policy, family leave policy, or medical leave policy. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences.

Deposits To Your Account

Payroll Deductions

Your contributions to your Account are made through pre-tax payroll deductions as authorized by your enrollment. The deductions are made before you pay federal, Social Security and, usually, state and local income taxes. You must determine your total deposits for the calendar year when you enroll. For more details, please refer to the latest annual enrollment information.

If you are on a leave of absence approved by the Participating Employer that allows you to continue participating in the Plan, the Plan Administrator has the full discretion to make special administrative arrangements as are necessary, such as suspending your contributions on a temporary basis during the leave of absence, and requiring you to contribute make-up deposits when you return to work, or any other arrangements that are permitted under applicable law that the Plan Administrator deems appropriate.

Note: Pre-tax deposits may reduce the Social Security benefit you are eligible for from the government because the pre-tax deposits are not included in your earnings used to calculate your Social Security benefit.

Deposit Amounts

You may elect to deposit from $100 to $5,000 ($10,500 for 2021 only) per family in your Account each year. When both you and your Spouse have access to employer-sponsored dependent care accounts, the total amount deposited in both accounts may not exceed $5,000 ($10,500 for 2021 only). If you and your Spouse file separate income tax returns, each of you is limited to $2,500 ($5,250 for 2021 only) in deposits to a dependent care account per year.

The total amount deposited per family may not exceed your earned income or that of your Spouse. Your Spouse is deemed to have earned income of $250 per month if you have one Qualifying Individual or $500 per month if you have two or more Qualifying Individuals for each month during which your Spouse is either (1) incapable of self-care and has the same principal place of abode as you for more than half of the year or (2) a full-time student.

Changing Deposit Amount

Your deposits into the Plan are made with pre-tax dollars through the Dow Flexible Spending Plan, a plan intended to qualify under Section 125 of the Internal Revenue Code (the "Code") as a "cafeteria plan." You may change the amount of your deposits only during annual enrollment, or if you have a "qualifying change in status" and you meet all of the consistency rules (as required by the terms of the Dow Flexible Spending Plan).

This section of the SPD describes the definition of "qualifying change in status," the "consistency rules," and the exceptions to these rules, as well as documentation required to change deposit amounts, deadlines for making these changes, and the Plan's authority to reduce benefit elections of certain Participants.

Any change or termination of your election for your Account may not result in, reducing your election to an amount that is less than the amount by which your Account is debited for qualified expenses incurred during the period prior to the effective date of your changed or terminated election. If your new, changed, or terminated election does not meet these requirements, it will be automatically adjusted so that your new election will equal the amount by which your Account has been debited for qualified expenses as of the effective date of the new election.

Reimbursement of Qualified Expenses

To be eligible for reimbursement from your Account, any qualified expenses must be incurred:

- for the care of a Qualifying Individual (as defined below) or for ordinary household services performed for the benefit of the Qualifying Individual by a Dependent Care Service Provider,
- on or after the date of your enrollment in the Plan, and
- in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, they must be a full-time student or be physically or mentally incapable of self-care.

Expenses incurred for the care received outside of your home for a Qualifying Individual, other than a child under age 13, are reimbursable only if the Qualifying Individual regularly spends at least eight hours each day in your household.

Types of Expenses that Are and Are Not Eligible for Reimbursement

Your Account will reimburse eligible dependent care expenses

In general, you may use your Account to reimburse the same types of expenses that qualify for the dependent care tax credit on your federal income tax return. IRS Publication 503 under the heading "Test to Claim the Credit" provides information regarding the types of expenses that qualify for the dependent care tax credit. Use the Publication with caution, however, because it was meant only to help taxpayers figure out whether they can claim the Dependent Care Tax Credit under Section 21 of the Code (described in the Dependent Care Tax Credit section). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under the Plan.

Your Account will also reimburse certain educational expenses

Certain educational expenses may be eligible for reimbursement from your Account, such as:

- Nursery school.
- Charges for after-school care for children under age 13.

Your Account will not reimburse ineligible expenses

Other expenses are not eligible for reimbursement from your Account, such as:

- Tuition charged for children in kindergarten and beyond,
- Food, clothing, overnight camp or entertainment,
- Nursing home care, or
- Care for a child after the child's 13th birthday. For example, if a child has their 13th birthday on January 31, no reimbursement may be made for expenses incurred on February 1 and for the remainder of the year.

Ask PayFlex if you need further information about which expenses are — and are not — likely to be reimbursable, but remember that PayFlex is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Dependent Care Service Provider

Dependent Care Service Providers generally include:

- A dependent day care center established and operating in compliance with applicable laws and regulations.
- An individual providing care in your home or at another location who is not your child (unless the child is age 19 or older by the end of the calendar year and is not claimed by you or your spouse as a dependent for income tax purposes) or someone for whom you could claim a deduction on your federal income tax return.
- Pre-school educational institutions, such as nursery school.
- Programs for school-age children during non-school hours.

Note: You are required to include your caregiver's Social Security or federal tax identification number each time you submit a reimbursement claim under the Plan.

Qualifying Individuals

You may seek reimbursement of expenses from your Account for "Qualifying Individuals." A Qualifying Individual is:

- A person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child under age 13 is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
- A person for whom you are entitled to claim a dependency deduction on your federal income tax return who is disabled and physically and/or mentally incapable of self-care and who resides with you for more than half the year (a "qualifying child" or "qualifying relative" as defined in Section 152(c) of the Code), or
- Your Spouse if they are disabled and physically and/or mentally incapable of self-care and who resides with you for more than half the year.

If you are a divorced parent, the Plan will recognize your biological or adopted child under age 13 as your Dependent if you have custody of the child, even if your former spouse, rather than you, is the one who is entitled to claim the dependency exemption. Under federal tax law, a non-custodial parent in a divorce situation cannot use the Plan to reimburse dependent care expenses for the child even if the non-custodial parent claims the child as a dependent for federal income tax purposes.

If You Leave Dow

If you leave Dow, retire, or transfer to an ineligible employee group, you may request to deduct a lump-sum from your last paycheck, your accrued vacation payment, or severance pay using pre-tax dollars, equal to an amount sufficient to fulfill the remainder of your annual election, or you may choose to suspend your Account. In either case you can use the amount in your Account toward qualifying expenses you incur during the remainder of the calendar year or during a grace period that extends until March 15 of the next year, even if you have suspended your deposits to the Plan. Your Account will remain open until the April 30 that occurs after the end of the year. After that date, any remaining balance will be forfeited. Note that your Claim for reimbursement must be received by the Claims Administrator on or before April 30 after the end of the Plan Year. Please see *DCFSA Claims Procedures* for more information about how to submit Claims.

Forfeitures

Any balance from the previous year that remains in your Account after the deadline for incurring and submitting claims must be forfeited. The Plan may have "experience gains" when the premiums (i.e., deposits) it receives from individual Participants exceeds their reimbursements for the Plan Year. Experience gains may be retained by the Company or used in any of the following ways, at the Plan Administrator's discretion:

- Defray reasonable administrative costs of the Plan.
- Increase coverage amount to Participants.

- Provide Participants with experience gains in the form of cash.

If the Plan Administrator decides to use experience gains to increase the coverage amount to Participants, the maximum annual amount that a Participant may elect to receive under the Plan may be increased by the amount of such experience gain allocated to such Participant. Under federal law, the total maximum amount may not exceed $5,000 ($10,500 for 2021 only). Therefore, Participants who are at the $5,000 maximum will not be able to receive any experience gains and those just under the $5,000 maximum ($10,500 for 2021 only) will be limited in the amount of experience gains that they will be able to receive.

Note that if the Plan Administrator distributes the experience gains to the Participants by increasing coverage or distributing cash, the specific Participants whose excess premiums contributed to such experience gains in any given Plan Year may not necessarily be the ones who will receive a distribution of the experience gains. The individuals who will receive the experience gains will be the Employees who are enrolled in the Plan during the Plan Year(s) in which the Plan Administrator has determined that a distribution of experience gains will be made. Such experience gains will be allocated to the Participants on a reasonable and uniform basis. Federal law prohibits basing the amount of experience gain to be distributed to each Participant on the amount forfeited by the Participant.

When determining the amount to deposit in your Account for the upcoming year, you can minimize your risk of forfeiture by reviewing your dependent care expenses from past years and anticipating changes.

Each time you are reimbursed from your Account, you may receive a withdrawal statement that shows recent deposits and your current balance.

Tax Considerations

Your Account contributions reduce your taxable income, allowing you to pay taxes on a smaller amount of income each payday. You may wish to consult a tax advisor to determine if the Plan or some other option is best for your situation. Neither the Company, nor any Participating Employer or any other affiliate, makes any assertion or warranty about (1) services that a Participant obtains, or obtains reimbursement for, as Plan benefits; or (2) the tax treatment of Plan coverage or benefits. You or your Dependents shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

The Dependent Care Tax Credit

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the Plan, although your qualified dependent care expenses in excess of that amount may be eligible for the Dependent Care Tax Credit.

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual qualified dependent care expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Dependent or $6,000 for two or more

Dependents. For example, if you elect $3,000 in coverage under the Plan and are reimbursed $3,000, but you had dependent care expenses totaling $4,000, then you could count the excess $1,000 when calculating the Dependent Care Tax Credit if you have two or more Dependents.

Depending on your adjusted gross income, the percentage of the Dependent Care Tax Credit could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Dependent or $2,100 for two or more Dependents). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000. For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses").

For most individuals, participating in the Plan will produce the greater federal tax savings, but there are some for whom the opposite is true. You should consult your own personal tax advisor.

DCFSA Claims Procedures

Claims for Reimbursement (Claims for Plan Benefits)

To receive reimbursement for dependent day care expenses, you must timely submit a Claim for reimbursement to PayFlex. You have not timely submitted a valid Claim unless you have submitted a completed Reimbursement Request Form or online reimbursement request, in each case with all information that the Claims Administrator requires, by the deadlines described below.

A Reimbursement Request Form is the document that describes the information that the Claims Administrator requires as part of a Claim. A Reimbursement Request Form can be obtained by calling HR Solutions at 833-MYDOWHR, or one can be printed off the Dow Benefits & Wellbeing website. When you submit the Reimbursement Request Form, you must attach any documents required by the Claims Administrator.

Online reimbursement requests may be submitted at www.payflex.com.

The Claims Administrator will require, among other information, the following:

- Copies of your receipts for dependent day care expenses. The receipts must show the date(s) of services.
- The name, address and social security number or federal income tax identification number of the caregiver.

Your Claims must be received by PayFlex by April 30 of the year following the year in which the expense is incurred. If you incur an expense during the grace period from January 1 through March 15, amounts remaining in your Account for the previous year will be used to reimburse the expense if it is submitted before April 30. For example, if you have $300 left in your Account on December 31, 2021, and you incur $300 of qualified expenses any time between January 1, 2022, and March 15, 2022, those expenses will be reimbursed from your remaining 2021 Account balance if they are submitted for reimbursement on or before April 30, 2022. Expenses are "incurred" when the dependent care that gives rise to the dependent care expenses is rendered, except as provided in the next paragraph.

For the 2020 and 2021 Plan Years only, the grace period is extended through the end of the subsequent Plan Year.

A reimbursement cannot be made before services have been rendered, unless the provider indicates the payment is non-refundable. If the payment is non-refundable, the reimbursement can be made 30 days in advance. If the payment is non-refundable, the Plan will treat the expense as incurred on the date payment to the provider is made, which date may not be more that 30 days prior to the date services are rendered.

PayFlex will not approve Claims for Reimbursement in excess of the balance in your Account.

A Reimbursement Request Form with the required supporting documentation can be mailed or faxed to:

PayFlex Systems USA, Inc.
PO Box 4000
Richmond, KY 40476-4000

Appendix H. Healthcare Assistance Program

Healthcare Assistance Program

Former SPD Name: N/A

Legal Plan Name: N/A

Legal Plan Number: N/A

Claims Administrators for Claims for Plan Benefits: To submit a claim for reimbursement (a Claim for Plan Benefits):
The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641

Eligibility
The Healthcare Assistance Program (the "HAP") provides financial assistance to Employees who meet the following criteria for the current calendar year:

- Make less than $75,000 per year in Base Pay or wages, and
- Enrolled in a Company medical plan.

Employees covered by a collective bargaining agreement are not eligible for the HAP, except where provided in their collective bargaining agreement.

For these purposes, Base Pay is defined as annual salary or annualized wages determined as of October 1 of the previous year. Performance award, overtime, bonuses, commissions, etc. are not included in Base Pay. For less-than-full time employees, pay is annualized based on a 40 hour per week schedule. For example, an employee who is scheduled to work 20 hours per week and whose annual salary is $35,000, will be considered to have Base Pay of $70,000 (2080/1040 x 35) for purposes of the HAP.

The HAP provides financial assistance in the form of (1) a reduction in premium, or (2) an employer HSA contribution, depending on the medical plan the employee is enrolled in during open enrollment or time of hire and the employee's eligibility to contribute to an HSA:

Medical Plan	**Savings**
Low Deductible (formerly MAP Plus Option 1)	10% reduction in your 2022 medical plan premiums
HMO	10% reduction of the Low Deductible Medical Plan premium for the coverage tier you elect

High Deductible (formerly the MAP Plus Option 2)	A contribution to your HSA equal to 10% of the 2022 Low Deductible Medical Plan premium for the coverage tier you elect

For the Low Deductible option, the amount of financial assistance is 10% of the full-time, non-tobacco-user, employee premium for the coverage tier that the employee elected during Annual Enrollment, with the following caveats:

- The employee's premium may not be less than $0
- The amounts will be rounded to the nearest whole dollar

Employees can forfeit eligibility under the program for the following reasons:

- The employee terminates employment with Dow (or a participating affiliate);
- The employee drops medical coverage; or
- For those enrolled in the HDHP who certify during Annual Enrollment that they are eligible to contribute to an HSA, the employee fails to open an HSA account at Fidelity, or whoever Dow has contracted with for HSA services, within current plan year.

Timing & Mid-Year Enrollment Changes

Financial assistance, when in the form of an HSA contribution, will be annualized and the contribution will be made at the beginning of the Plan Year or, if later, at the time the participant opens the HSA account within the current Plan Year.

Financial assistance, when in the form of a reduction in premium, will be provided as a reduction in premium for the entire calendar year.

A change in tier does not result in a change to the amount of financial assistance. The amount of financial assistance is based upon the tier the employee elected during annual enrollment.

An employee who receives an annual HSA contribution is not eligible for additional financial assistance for the remainder of the year, regardless of any changes in plan or tier.

An employee who receives a reduction in premium who switches to another medical plan option, and whose form of financial assistance under that option is also a reduction in premium, will continue to receive the same reduction in premium. If an employee switches to the HDHP and is eligible to make HSA contributions, that employee will receive a one-time HSA contribution equal to their full years' worth of financial assistance less any financial assistance received year to date in the form of a reduction in premium.

New Hire Employees

The amount of discount for new hire employees is based on the employee's hire date. Those hired after January 1 and who meet all the other eligibility criteria are eligible to receive prorated

financial assistance based on their starting salary at the time of hire. Contributions will be prorated depending on medical option selected, as described below:

- If an employee enrolls in the low deductible PPO or an HMO option, the premium subsidy will begin as soon as administratively practical and the per paycheck subsidy will be the same as an eligible employee who was hired on or prior to January 1 of the current year.
- If an employee enrolls in the HDHP option, the amount of the HSA contribution will be based on the quarter the employee was hired, as described below:

Quarter Hired	**HSA Contribution**
Q1	Full Amount
Q2	3/4 Full Amount
Q3	1/2 Full Amount
Q4	1/4 Full Amount