Summary Plan Description for:

The Dow Chemical Company
Retiree Medical Care Program's

Basic/Supplemental (Old) Plan
Comprehensive (New) Plan
(ERISA Plan #501)

APPLICABLE TO ELIGIBLE RETIREES WHO RETIRED BEFORE JAN. 1, 1993

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

This Summary Plan Description (SPD) is updated annually and supersedes all prior SPDs.

Content Steward: Theis
January 1, 2014
Literature #TBD

THE DOW CHEMICAL COMPANY
ADOPTION OF SUMMARY PLAN DESCRIPTIONS

WHEREAS, The Dow Chemical Company ("Dow") sponsors The Dow Chemical Company Medical Care Program (the "Medical Program"), The Dow Chemical Company Retiree Medical Care Program (the "Retiree Medical Program"), and The Dow Chemical Company Insured Health Program (the "Insured Health Program" and together with the Medical Program and the Retiree Medical Program, the "Programs");

WHEREAS, Dow offers various self-funded health maintenance organizations ("HMOs") to active employees under the Medical Program, insured medical plans and HMOs for retirees under the Insured Health Program, and the MAP Plus Option 1 Low Deductible Plan, the MAP Plus Option 2 High Deductible Plan, the Basic/Supplemental Plan (Old Plan), the Comprehensive Plan (New Plan), and various self-funded HMOs for retirees as component plans under the Retiree Medical Program (such component plans, HMOs, and insured plans referred to herein as the "Plans");

WHEREAS, Dow reserves the right, by action of the undersigned, to amend or modify the Programs including, without limitation, the Plans and the Summary Plan Descriptions for the Plans, in accordance with Article VII of the plan documents for the Programs; and

WHEREAS, Dow wishes to adopt revised Summary Plan Descriptions for the Plans.

NOW, THEREFORE, BE IT RESOLVED, Dow adopts the following Summary Plan Descriptions for the Plans as amended and restated substantially in the form attached hereto and bearing the following covers:

Summary Plan Description for:

The Dow Chemical Company
Retiree Medical Care Program's

Map Plus Option 1 Low Deductible Plan and MAP Plus Option 2 High Deductible Plan (ERISA Plan #501)

Applicable to Eligible Retirees

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

Summary Plan Description "Wrapper" for:

Health Maintenance Organizations (HMOs) and Insured Health Plans Participating in:

The Dow Chemical Company Insured Health Program (ERISA Plan #601)

Applicable to Eligible Retirees

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

Summary Plan Description for:

The Dow Chemical Company Retiree Medical Care Program's

Basic/Supplemental (Old) Plan
Comprehensive (New) Plan
(ERISA Plan #601)

Applicable to Eligible Retirees Who Retired Before January 1, 1993

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

Summary Plan Description for:

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

Self-Funded HMO Plans

(ERISA Plan #501)

Applicable to Eligible Active Employees & Pre-Medicare-Eligible Retirees

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

RESOLVED, FURTHER, that all prior versions of the foregoing Summary Plan Descriptions for the Plans are superseded.

* * * *

By: _____
Bryan Jendretzke
Global Benefits Director
The Dow Chemical Company

Reviewed by Plan Administrator:

_____
Diane Dittenhafer

Reviewed by Legal Department:

_____
Kenneth H. Hemler

Dated: October 31, 2014

Table of Contents

Section 1. ERISA Information

Summary Plan Description for The Dow Chemical Company Retiree Medical Care Program's Basic/Supplemental ("Old") Plan and Comprehensive ("New") Plan Applicable to Eligible Retirees	
Type of Plan	Group health plan
Type of Plan Administration	Self-insured benefits administered under contract with Aetna.
Plan Administrator	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661
Employer Identification Number	38-1285128
Plan Number	501
Plan Sponsor	The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Retiree Service Center	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661
Claims Administrator for Claims for Plan Benefits	*To submit a Claim for Plan Benefits:* Aetna, Inc. P.O. Box 981106 El Paso, TX 79998-1106 (800) 7DOWDOW *To appeal a denied Claim for Plan Benefits*: Aetna, Inc. Attn: National Accounts CRT P.O. Box 14463 Lexington, KY 40512

Claims Administrator for Claims for an Eligibility Determination	*To submit a Claim for an Eligibility Determination:* North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661 *To appeal a denied Claim for an Eligibility Determination*: Associate Director of North America Benefits/ Global Benefits Director The Dow Chemical Company Employee Development Center Midland, Michigan 48674
To Serve Legal Process	General Counsel The Dow Chemical Company 2030 Dow Center Midland, MI 48674
COBRA Administrator	Towers Watson BenefitConnect COBRA Service Center P.O. Box 919051 San Diego, CA 92191-9863 (877) 292-6272
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	The Company shares the premium costs with Retirees. Benefits are paid from the Company's general assets. The Company's contribution to Program costs is limited to the contribution limits established in April 1994, and amended in July 2001, unless adjusted by the Company. The assets of the Program, if any, can 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 can include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.

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

Section 2. Introduction

This is the Summary Plan Description (SPD) for the Basic/Supplemental Plan ("Old Plan") and Comprehensive Plan ("New Plan"), offered under The Dow Chemical Company Retiree Medical Care Program (the "Program"). The provisions of this SPD apply only to the Old Plan and the New Plan. The provisions of this SPD apply to eligible Retirees who retired before January 1, 1993.

In this SPD, the Old Plan and the New Plan are referred to collectively as the "Plans," and individually as a "Plan." In addition to the Plans, Dow offers other medical plans under the Program. Check www.dowfriends.com or call the Retiree Service Center at (800) 344-0661 for information about other plans that may be available to you.

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

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

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

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

Capitalized words in this SPD are defined either in the Plan Document for the Program, in *Section 29. Definitions of Terms*, or in the applicable *Description of Plan Benefits (Appendix A)* for the specific Plan. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

About Appendix A (Description of Plan Benefits)

Appendix A of this SPD contains the Description of Plan Benefits. There is a separate Appendix A for each Plan described in this SPD: one that addresses the Old Plan and a separate one that addresses the New Plan. You should pay special attention to the Appendix A of this SPD that is applicable to the Plan in which you are enrolled. Appendix A describes:

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

Section 3. Eligibility

As explained in this section of the SPD, the Program provides Plan coverage for certain Retirees and disabled individuals, as well as certain dependents. Survivor eligibility is summarized in *Section 8. Survivor Benefits*.

3.1 Retiree Eligibility

The Program is applicable to eligible Retirees of a Participating Employer who meet all of the requirements below ("Retiree" is defined in the Plan Document and summarized in *Section 29. Definitions of Terms*):

- You Retired before January 1, 1993;
- You were enrolled on the day preceding your Retirement in the respective Basic Supplemental (Old) Plan or Comprehensive (New) Plan that was available to active Employees before January 1, 1993;
- You have been continuously covered by either the Old Plan, the New Plan, or an HMO or the Aetna Medicare Advantage PPO under The Dow Chemical Company Insured Health Program. (See *Section 5.4 Re-Enrollment After* Waiving Coverage); and
- You reached age 65 before January 1, 1997 (or before January 1, 1996 if you live in the Midland/Bay City/Saginaw area).

If you are not eligible for coverage because you fail to meet one of the requirements above, you still may eligible for the MAP Plus Option 1 Low Deductible Plan, the MAP Plus Option 2 High Deductible Plan (if you are not Medicare-eligible), or an HMO or PPO plan, subject to the eligibility requirements for each plan and for each Dow retiree medical program under which the plan is offered.

If you are a Surviving Spouse of Record/Domestic Partner of Record under age 65, or a surviving Dependent Child of both an eligible Retiree and his or her Surviving Spouse of Record /Domestic Partner of Record (if any), you must elect a plan equivalent to the plan(s) available to active employees living in the areas in which you have your permanent address. Contact the Retiree Service Center to obtain a Retiree MAP Plus Summary Plan Description.

You may also be eligible for Plan coverage under the Program if, before January 1, 1993, you were approved to receive a benefit under, and were and continue to be "totally and permanently disabled" as defined by The Dow Chemical Company Long Term Disability Program, The Dow Chemical Company Texas Operations Total & Permanent Disability Plan, or another Participating Employer Sponsored Disability Plan.

Medicare Prescription Drug Coverage/Medicare Advantage Plan Exclusion

If you enroll in prescription drug coverage offered under either a Medicare Advantage Plan (that provides Medicare prescription drug coverage) or a Medicare prescription drug plan (Medicare Part D) that is not sponsored by Dow, you are ***NOT*** eligible for coverage under the Program. You cannot be enrolled in **both** the Program and a Medicare Advantage Plan (that provides Medicare prescription drug coverage) or separate Medicare prescription drug coverage at the same time. Similarly, none of your Dependents may be enrolled in **both** the Program and a Medicare Advantage Plan (that provides Medicare prescription drug coverage) or a Medicare prescription drug plan.

3.2 Dependent Eligibility

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

The Program reserves the right at any time to request proof of Dependent eligibility, such as birth certificates, passports, Marriage certificates, Domestic Partner signed statements or any other form of proof the Plan Administrator deems appropriate.

Spouse of Record/Domestic Partner of Record

Your Spouse of Record or Domestic Partner of Record is generally your Spouse or Domestic Partner as of December 31, 2002.[1] If you marry, remarry or enter into a new Domestic Partnership after December 31, 2002, your new Spouse or Domestic Partner generally is NOT eligible for coverage under any Dow-sponsored retiree medical program. However, if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married. Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement and the exception described in the preceding sentence does not apply, your new Spouse's or Domestic Partner's children (e.g., your step-children) who are not your birth or legally adopted children are not generally eligible for coverage under any Dow-sponsored retiree medical program.

Spouse of Record/Domestic Partner of Record Exclusions

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

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

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

[1] For DAS Retirees, the applicable date is December 31, 2005, instead of December 31, 2002.

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

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

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

- If your Spouse of Record/Domestic Partner of Record has enrolled in coverage offered by his or her employer (or former employer), the payment of benefits under the Plan will be secondary to your Spouse of Record/Domestic Partner of Record's coverage through his or her employer (or former employer) under the Plan's coordination of benefits rules.
- If your Spouse of Record/Domestic Partner of Record fails to enroll in appropriate coverage available through his or her own employer (or former employer):
    1. You will be charged 102% of the full cost of coverage (*i.e.*, without any employer subsidy, if applicable) retroactive to the first day that your Spouse of Record/Domestic Partner of Record was enrolled in the Plan and failed to enroll in his or her own employer's coverage.
    2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide proof that your Spouse of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer), the Program may cancel coverage for you and/or your Spouse of Record/Domestic Partner of Record retroactive to the first day that your Spouse of Record/Domestic Partner of Record 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 25. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while you and/or your Dependent were not eligible for coverage.
    3. If you pay 102% of the full cost of coverage but you do not provide proof that your Spouse of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer by the date determined by the Plan Administrator, coverage will terminate as of the date that the Program learns that your Spouse of Record/Domestic Partner of Record 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 of Record/Domestic Partner of Record has since enrolled in the appropriate coverage through his or her employer, your Spouse of Record/Domestic Partner of Record will remain covered under the Plan for the Plan Year.

    Additional or alternative actions might be taken on account of your or your Spouse of Record/Domestic Partner of Record's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

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

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

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

Dependent Child(ren)

A child is eligible for coverage under the Program if the child meets the definition of "Dependent Child." A "Dependent Child" is a child who must be:

- your birth or legally adopted child; or
- your Spouse of Record's or Domestic Partner of Record's natural or adopted child; or
- a child for whom you or your Spouse of Record or Domestic Partner of Record 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. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:
  - authority to consent to the child's marriage or adoption, or
  - authority to enlist the child in the armed forces of the U.S.;
  - right to the child's services and earnings; and
  - power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

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

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

Dependent under Dow retiree medical coverage prior to March 1, 2013, and remains continuously covered under Dow retiree medical coverage.

Dependent Child(ren) Exclusions

Your Dependent Child will not be eligible for coverage under the Program if he or she:

- *Reaches age 26.* Coverage ends on the child's 26th birthday. 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 the Retiree Service Center 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 must 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 11.2 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 the Retiree has a "qualified medical child support order" for that child. A Qualified Medical Child Support Order ("QMCSO") is a court order that meets the Program's requirements to provide a child the right to be covered under one of the Plans offered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent, assuming you are eligible for coverage under the Program.

Typically, a divorce decree that orders the Retiree to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree (or document signed by either the Retiree or the custodial parent provided with the divorce decree and consistent with the divorce decree) contains the following information:

- The name and last known mailing address of each child for whom the Retiree must provide medical coverage;
- A reasonable description of the type of coverage to be provided to the child; and
- The period for which the coverage is to be provided (within the Program's rules).

Note that if there is any ambiguity in, or between, the document(s) signed by the Retiree or custodial parent, the Program reserves the right to require the Retiree and/or custodial parent to obtain a court order to resolve the ambiguity.

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

3.3 Eligibility Determinations of Claims Administrator are Final and Binding

The applicable Claims Administrator determines eligibility. The Claims Administrator is a fiduciary of the Program and has the full discretion to interpret provisions of the SPD and the Plan Document and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants. If you would like the applicable Claims Administrator to determine whether you are eligible for coverage, you can file a Claim for an Eligibility Determination. See *Section 26. Claims Procedures*.

Section 4. Medicare

4.1 Medicare Enrollment

If You Become Eligible for Medicare Parts A and B After You Retire

In general, if you are not yet Eligible for Medicare, you must enroll in Medicare Parts A and B ***during the three month period before you reach age 65*** in order to continue receiving benefits under the Plan. If you become Eligible for Medicare earlier than age 65 (e.g., due to disability), you must enroll in Medicare parts A and B within the deadlines set by Medicare and you may also enroll in a Dow Medicare Advantage Plan.

Similarly, if your Spouse of Record/Domestic Partner of Record is becoming eligible for Medicare, he or she must enroll in Medicare Parts A and B ***during the three month period before he or she reaches age 65*** (or by the deadline set by Medicare including for enrollment upon disability) in order to continue receiving benefits under the Plan.

Once enrolled in Medicare, you may be eligible for reduced premiums under the Program. To do so, you must contact the Retiree Service Center promptly to inform Dow of the Medicare enrollment.

If You Retire At or After You Reach Medicare Eligibility Age

- If you become a Participant under the Program when you reach age 65, you must enroll in both Parts A and B of Medicare ***during the three month period before you reach age 65***.
- If you Retire after reaching age 65, you should enroll in Medicare Part A during the three month period before you reach age 65, and in Medicare Part B during the three month period prior to your Retirement.
- You may enroll in a Dow Medicare Advantage Plan. A prerequisite to enrolling in a Medicare Advantage Plan is for you to enroll in Medicare Parts A and B.

Consequences of *Not* Enrolling in Medicare

If you do not enroll in Medicare Parts A and B according to these guidelines, your benefits under the Program will be reduced by the amount that would have been covered by Medicare Parts A and B if you had enrolled, as of the date you were first Eligible for Medicare. For details about Medicare, obtain a copy of Your Medicare Handbook from your local Social Security Office or the Health Care Finance Administration, or contact one of those offices with your questions. For more information about Dow retiree benefits relative to Medicare, see the section "*COB with Medicare*" in Appendix A of this SPD (the Description of Benefits).

Deadline to Notify the Plan Administrator of a Change in Medicare Eligibility

If you become eligible, or your Dependent becomes eligible, for Medicare due to disability or for any other reason before you (or your Dependent) reach age 65, you (or your Dependent) must enroll in Medicare Parts A and B within the deadlines set by Medicare in order to continue to be eligible for coverage under the Program.

- If you notify the Plan Administrator within 31 days before the date you become eligible for Medicare, coverage and premiums under the Program will be adjusted effective as of the date of Medicare eligibility.
- If you notify the Plan Administrator within 90 days after becoming eligible for Medicare, coverage under the Program will be adjusted effective on the first of the first month after the Plan Administrator receives the notification and any change in premiums will be made as soon as practicable after the date of your notification to the Plan Administrator.
- If you do not notify the Plan Administrator within 90 days of becoming eligible for Medicare, coverage will be corrected to the date the Plan Administrator deems administratively feasible. You will be responsible for any difference in premium contributions. In addition, to the extent that the Program has paid any benefits primary to Medicare but should have paid secondary to Medicare, you will be responsible to reimburse it for the amount of that overpayment even though your premiums may not change.

If you cease to be eligible for Medicare (e.g., because you qualified for Medicare as a result of a Social Security disability benefit and you are no longer disabled), you must notify the Plan Administrator of the change in eligibility within 90 days.

4.2 Your Dow Coverage Pays Secondary to Medicare Parts A and B

The Plan pays benefits that are secondary to the benefits provided under Medicare Parts A and B. Any service covered by Medicare must be received from a Medicare-approved provider in order to be eligible for secondary coverage under the Plan.

4.3 Medicare Part D

Medicare offers prescription drug coverage to Medicare retirees through "Medicare prescription drug plans," or Medicare Part D. Medicare prescription drug plans provide ***standard*** Medicare prescription drug coverage. For more information about Medicare prescription drug coverage, or what ***standard*** Medicare prescription drug coverage entails, contact Medicare at (800) 633-4227, or access Medicare's website at www.medicare.gov. If you join a Medicare prescription drug plan that is not sponsored by Dow, you will be disqualified from participation in ANY Dow-sponsored retiree medical plan while you are enrolled in the Medicare prescription drug plan. However, if you were enrolled in Medicaid and you lose coverage on account of becoming enrolled in a Medicare prescription drug plan, your Dependents may continue to participate in the Program as long as they are not enrolled in a Medicare prescription drug plan. The Dependent must continue to pay the cost of coverage under the Plan in accordance with the rules described in *Section 8. Survivor Benefits*.

The Plans provide prescription drug coverage at least as good as or better than Medicare prescription drug coverage (Medicare calls this "creditable coverage"). The prescription drug coverage for Medicare retirees under the MAP Plus Option 1 Low Deductible plan is considered a Medicare Part D plan.

You should carefully consider whether enrolling in the Plan or enrolling in a non-Dow sponsored Medicare Part D is better for you. Refer to *Appendix C, Important Notice of Creditable Coverage for Medicare-Eligibles*. You might also want to consider the following factors:

- Are you, or can you be, covered under your Spouse's retiree medical plan as a dependent? If so, does your Spouse's coverage provide "creditable coverage"?
- Will coverage under Medicare Parts A, B and D be sufficient for you?
- How do the premium costs of your various options compare?
- What medications are you taking, and are they covered under the options you are considering?
- Dow Medicare Advantage Plans provide comprehensive medical coverage, including prescription coverage that is "creditable coverage". See *Section 4.4 Medicare Advantage Plans*, below.

There may be other factors you should also consider depending on your own personal situation.

4.4 Medicare Advantage Plans

Medicare Advantage Plans are health plans approved by the government that offer Medicare participants additional options beyond Medicare A and B. Prior to January 1, 2006, they were called "Medicare Part C" plans, or "Medicare Plus Choice" plans. For more details, you can contact Medicare by calling 1-800-MEDICARE (1-800-633-4227), or accessing the Medicare website at www.medicare.gov.

Dow supplements the cost of certain plans offered under Medicare Advantage. These plans are called "Dow Medicare Advantage Plans" and are offered under The Dow Chemical Company Insured Health Program, which is different from the Program. Each fall, your enrollment materials will contain a listing of Dow Medicare Advantage Plans. If you decide to enroll in one of the Dow Medicare Advantage Plans:

- you must enroll in Medicare Parts A and B and pay Medicare premiums,
- you may enroll in one of the Plans (if you are otherwise eligible), and
- a portion of your care is paid by Medicare and a portion is paid by Dow.

For more information about coverage under the Dow Medicare Advantage Plans, see the Summary Plan Description "Wrapper" applicable to eligible retirees for the HMOs and Insured Health Plans Participating in The Dow Chemical Company Insured Health Program (ERISA Plan #601). If you have specific questions about the Dow Medicare Advantage Plans, contact Secova, Dow's HMO manager at (800) 858-4347.

If you enroll in a Medicare Advantage Plan (i.e., a Medicare Advantage Plan that has not been approved by Dow), you are not eligible for coverage under the Program. As previously mentioned, to be eligible for the Plan, you must continue to be enrolled in Medicare Parts A and B and not a non-Dow Medicare Advantage Plan. If you enroll in a non-Dow Medicare Advantage Plan and later decide you are not satisfied, you may go back to Medicare Parts A and B. Your re-enrollment in the Plan is subject to the rules in *Section 5.4 Re-Enrollment After* Waiving Coverage. You can elect to switch plans once per year. Medicare has set up a web site at www.medicare.gov to provide a broad array of information about its benefits.

Section 5. Enrollment

5.1 Levels of Participation

The levels of participation available are:

- Individual Only
- Individual plus Spouse of Record
- Individual plus Domestic Partner of Record

- Individual plus Child(ren)
- Individual plus Spouse of Record and Child(ren)
- Individual plus Domestic Partner of Record plus Child(ren)

You must be enrolled in order to enroll your Spouse of Record/Domestic Partner of Record or Dependent Child. In general, you may enroll your Dependent only in the same Plan in which you are enrolled.

5.2 Enrolling at Retirement

Coverage under one of the Plans is limited to individuals who Retired before January 1, 1993, enrolled in accordance with the procedures then in effect, and remain enrolled in the Plan. See *Section 3.1 Retiree Eligibility*. Current Employees may no longer enroll in either Plan at their Retirement.

5.3 Annual Enrollment

Annual enrollment is typically held during the last quarter of the year. No new Retiree enrollments in the Plan are permitted after January 1, 1993.

You may add an eligible Dependent, or drop a Dependent, during annual enrollment. If you wish to add a Dependent – either a Spouse of Record/Domestic Partner of Record or an eligible child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. If you are adding a Spouse of Record/Domestic Partner of Record, be sure that he or she meets the Plan's definition of Spouse of Record/Domestic Partner of Record.

You must provide proof of Dependent eligibility no later than March 31st of the applicable Plan Year. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate.

If you do not provide proof of Dependent eligibility by March 31st:

1 You will be charged 102% of the full cost of coverage (*i.e.*, without any employer subsidy, if applicable) retroactive to the first day that your Dependent was enrolled in the Plan.

2 If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for your Dependent retroactive to the first day that your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for your Dependent. See *Section 25. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while your Dependent was not eligible for coverage.

3 If you pay 102% of the full cost of coverage but you do not provide acceptable proof of Dependent eligibility by the date determined by the Plan Administrator, your Dependent's coverage will terminate as of March 31st.

4 If, as of the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of Dependent eligibility, your Dependent will remain covered under the Plan, as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

If your Spouse of Record is enrolled in a Plan, you may not dis-enroll your Spouse of Record in anticipation of a divorce. You are required to continue coverage for your Spouse of Record and pay the applicable premium. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended

(COBRA), when your legal separation or divorce is final, your Spouse of Record has a right to continue coverage under the Plan at 102% of the full cost of coverage for a certain period of time. See *Section 11.2 COBRA Continuation Coverage* for more information about COBRA coverage.

Default Enrollment

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

5.4 Re-Enrollment After Waiving Coverage

If you waive coverage or, in general, if you change coverage to another Dow plan, you may not re-enroll in either Plan. The only exception to this rule is that, if you change from the Old Plan or New Plan directly to an HMO or the Aetna Medicare Advantage PPO under The Dow Chemical Company Insured Health Program, you may later change back directly to either the Old Plan or the New Plan (whichever one in which you were previously enrolled).

Otherwise, if you waive coverage, you may be able to enroll in Dow retiree medical coverage (but not in either of the Plans) during annual enrollment or under a special enrollment provision, if you meet the eligibility requirements for the other Dow retiree medical coverage. Contact the Retiree Service Center for more information.

5.5 Dual Dow or UCC Coverage

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

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

Section 6. Mid-Year Election Changes

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

Otherwise, you may change your Plan coverage level mid-year only by adding a Dependent, and you may do so only if you have a "change in status" AND you meet all of the consistency rules. The Program administers change in status events and the consistency rules the same way with respect to Domestic Partners of Record as Spouses of Record, to the extent that such administration does not jeopardize the tax-qualified status of the Program.

This section of the SPD describes 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.

6.1 Change in Status

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

- Divorce or Termination of Domestic Partnership, or death of your Spouse of Record/Domestic Partner of Record.
- Birth, adoption or placement for adoption, or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- A change in the place of residence or work of you or your Spouse of Record/Domestic Partner of Record or Dependent Child.
- Your Dependent satisfies or ceases to satisfy the definition for "Dependent Child."
- Your Spouse of Record/Domestic Partner of Record or Dependent Child gains eligibility for coverage under his or her employer's health plan.

6.2 Consistency Rules

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

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

6.3 Exceptions to the Change in Status and Consistency Rules

You may change your medical 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 medical plan election.
- ***Significant Cost or Coverage Changes*** – If your Spouse of Record/Domestic Partner of Record is covered by his or her employer's plan, which allows him or her to change his or her benefit plan election because of a significant change in cost or coverage under the employer's plan, such change in your Spouse of Record/Domestic Partner of Record's election may allow you to change your Dow election. If your Spouse of Record/Domestic Partner of Record's employer's enrollment period is different from Dow's, your Spouse of Record/Domestic Partner of Record's election under his or her employer's plan may constitute a significant coverage change allowing you to change your Program election.
- ***Entitlement to Medicare or Medicaid*** – If you, your Spouse of Record/Domestic Partner of Record, or your 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. (*Note:* You may not be eligible to continue your Plan coverage under the Program. See *Section 4. Medicare*.)

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

In general, you are required to provide proof of eligibility to make an election change and/or proof of Dependent eligibility by day 90 after the change in status event. If you do not provide such proof within 90 days after the change in status:

1. You will be charged 102% of the full cost of coverage (*i.e.*, without any employer subsidy, if applicable) retroactive to the first day that you and/or your Dependent was enrolled in the Plan.
2. If you fail to pay 102% of the full cost of coverage by the date determined by the Plan Administrator (whether or not you provide acceptable proof of Dependent eligibility), the Program may cancel coverage for you and/or your Dependent retroactive to the first day that you and/or your Dependent was enrolled in coverage. If coverage is cancelled retroactively, you will be required to reimburse the Plan for claims paid during the coverage period for you and/or your Dependent. See *Section 25. Payment of Unauthorized Benefits*, for rules that apply if the Plan paid benefits while your Dependent was not eligible for coverage.
3. If you pay 102% of the full cost of coverage but you do not provide acceptable proof of eligibility by the date determined by the Plan Administrator, coverage will terminate as of the 90th day after your change in status event.
4. If, by the date determined by the Plan Administrator, you pay 102% of the full cost of coverage and you provide acceptable proof of eligibility, you and/or your Dependent will remain covered under the Plan, as long as you continue to pay 102% of the full cost of coverage for the remainder of the Plan Year.

Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentation. See *Section 10. Fraud Against the Program*.

Dropping a Dependent

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

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

6.5 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the Fall of each year), you must submit the required proof of eligibility and request enrollment within 90 days of the change in status event 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 you are not Medicare eligible and:
    - If the Plan Administrator receives your enrollment request within 31 days of the change in status event, the effective date of the mid-year election change will be the date of the change in status event.
    - If the Plan Administrator receives your enrollment request on day 32 through 90 after the change in status event, the effective date of the mid-year election change will be the Plan Administrator's processing date.
- In all other cases, if you are Medicare-eligible and:
    - If the Plan Administrator receives your enrollment request within 31 days prior to the change in status event, the effective date of the mid-year election change will be the first of the month following the date of the event.
    - If the Plan Administrator receives your enrollment request within 90 days after the change in status event, the effective date of the mid-year election change will be the first of the month following the date the Plan Administrator receives your enrollment request.

Section 7. Premiums and Premium Cap

You and Dow share the premium costs for your medical coverage, according to the guidelines set forth in the Plan Document and summarized in this section of the SPD.

7.1 Retiree Medical Budget (Maximum Dow Subsidy, or the "Premium Cap")

The Company has established a retiree medical budget. The Retiree Medical Budget is the maximum amount that the Company will pay toward medical premiums for the Program and for The Dow Chemical Company Insured Health Program (as applicable to HMOs and insured plans available to Retirees, except for the International Medical and Dental Plan). ***This budget affects premiums only, not benefit amounts paid for medical services. The Company may contribute less than the maximum set under the Retiree Medical Budget, in its sole discretion.***

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

- the number of Medicare-eligible Retiree Medical Participants;
- the number of Retiree Medical Participants not Eligible for Medicare; and
- whether the Retiree Medical Participants have Full Service or have reduced support based on the Retiree Medical Support Schedule.

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

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

PLUS

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

The Company allocates all of the Retiree Medical Budget first to the prescription drug portion of the Program, with any remaining portion of the Retiree Medical Budget allocated to the remainder of the Program.

In addition, the Company contributes proportionally less for each Retiree Medical Participant with less than Full Service who is subject to the Retiree Medical Support Schedule. Once the Company has calculated the total budget for the upcoming year, the budget is allocated so that Full Service pre-Medicare-eligible Retiree Medical Participants and Full Service Medicare-eligible Retiree Medical Participants pay a similar percentage of the cost of their coverage as premiums. This allocation determines the maximum Company subsidy, or is the "cap" on the amount the Company will subsidize the premium for a Retiree Medical Participant with and without Medicare. Retiree Medical Participants are responsible for the portion of the total cost of retiree medical care coverage above the cap.

Each fall, the Company publishes retiree medical premiums for the various retiree medical plans for the following year. These premiums will be affected by whether or not the Retiree Medical Budget will be exceeded in the coming year. ***In years after the Retiree Medical Budget is exceeded, your retiree medical premium will increase significantly.***

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

7.2 Eligible Retirees Are Deemed Full Service Retirees

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

7.3 If Medicare is NOT the Primary Payer

In general, if you are enrolled in coverage under the Program and you are Eligible for Medicare, Medicare is the primary payer of benefits (and your coverage under the Program is secondary) – even if you have not enrolled in Medicare.

However, if Dow provides the primary coverage instead of Medicare, you will be required to pay the premiums applicable to pre-Medicare-eligible Retirees. This could apply if, for example, you reside outside the U.S., or you have been approved for disability benefits under the Michigan Operations Contract Disability Plan, in which case you pay the applicable rates for active employees.

7.4 Disabled Participants

If, before January 1, 1993, you were approved to receive a benefit under, and were and continue to be "totally and permanently disabled" as defined by The Dow Chemical Company Long Term Disability Income Protection Plan, The Dow Chemical Company Texas Operations Total & Permanent Disability Plan, or any other Participating Employer Sponsored Disability Plan, Dow pays for your cost of medical coverage for the period of time and for the circumstances described in those plans.

7.5 Premium Payments/Excess Premium Payments

If your monthly premium amount is less than your monthly Dow Employees' Pension Plan pension payment amount, the Plan requires that your premium be paid from a deduction from your monthly pension payment. If your monthly premium amount is equal to or greater than your monthly pension payment amount, then your premium will not be deducted from your pension payment, but you will be billed for the premium.

Your failure to pay the full amount of premiums due by the date required by the Plan Administrator may result in no coverage or in cancellation of coverage, including retroactive termination of coverage. The Plan Administrator, in its sole discretion, may determine whether you are delinquent in paying premiums. In general, you are considered delinquent if required premiums are more than 30 days past due. If you become delinquent in paying premiums:

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

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

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

Section 8. Survivor Benefits

8.1 Surviving Spouse of Record/Domestic Partner of Record of Deceased Retiree (who Retired Before Jan. 1, 1993)

In general, a Surviving Spouse of Record/Domestic Partner of Record of a deceased Retiree (including a deceased Disability Retiree) is eligible to continue coverage under the Plan if (and only if) the Surviving Spouse of Record/Domestic Partner of Record was enrolled in the Plan at the time of the Retiree's death. (If the Surviving Spouse of Record/Domestic Partner of Record was not enrolled in the Plan at the time of the Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be eligible for other coverage under the Program or in a different Dow retiree medical program. Contact the Dow Retiree Service Center for more information.)

If a Surviving Spouse of Record/Domestic Partner of Record is employed full time or is retired, and his or her employer (or former employer) offers medical coverage, the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that plan in order to obtain coverage under the Program.

Currently, Dow pays the full cost to insure for a Surviving Spouse of Record/Domestic Partner of Record of a deceased Disability Retiree whose disability retirement was approved prior to January 1, 2006. For all other Survivors described in this section, the Retiree Medical Support Schedule and Retiree Medical Budget apply to determine the applicable premium the Survivor must pay for coverage.

In order to be covered, an eligible Surviving Spouse of Record/Domestic Partner must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.

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

If the deceased former Employee is a Participant in the Plan who had a disability approved for receipt of benefits under the Texas Total and Permanent Disability Plan or Michigan Contract Disability Plan, the Surviving Spouse of Record/Domestic Partner of Record is not required to pay a premium for coverage under the Plan.

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

Effective September 14, 2000, remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record from eligibility for coverage. A Surviving Spouse of Record/Domestic Partner of Record may not cover his or her new spouse or domestic partner under the Program. If the Surviving Spouse of Record/Domestic Partner of Record waived coverage at the time of the Employee's or Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record may enroll for coverage only during annual enrollment or if there is a change in status. See *Section 5.4 Re-Enrollment After* Waiving Coverage.

8.4 Surviving Children

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

If there is no Surviving Spouse of Record/Domestic Partner of Record, surviving Dependent 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 the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Dow subsidizes the COBRA premiums for the first 12 months: surviving Dependent Children pay the premiums applicable to the Retiree for up to one year after the date of 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 of coverage. *In order to be covered, the surviving Dependent Children must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

Section 9. Notices

The following notices are prescribed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborn's and Mother's Health Protection Act of 1996, and other federal legislation. The Plans are not subject to many of the legal requirements described in these notices. See "Retiree-Only Coverage" under *Section 1. ERISA Information*. However, to the extent provided in the applicable Appendix, the Plans may have elected to voluntarily comply with these requirements.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires notice that certain reconstructive surgery after a mastectomy is covered to the extent required by law. While each Plan provided coverage for such surgery prior to the enactment of this law and may continue to provide this coverage despite being a retiree-only plan, this paragraph provides notice of rights under the law. If a Participant receives benefits covered under the Plan in connection with a mastectomy and elects breast reconstruction, the Plan will provide coverage for:

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

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

benefits, you may contact the Plan Administrator at the address or telephone number listed in *Section 1. ERISA Information*.

Maternity Stays

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

Certificates of Coverage

When your Program coverage ends, Dow will mail you a certificate of coverage stating the dates you were covered under the Program and the type of coverage you had. If you enroll for medical coverage under another employer-sponsored health plan that includes a waiting period, your new employer is required under the Health Insurance Portability and Accountability Act to credit your Program coverage towards the waiting period. If you elect to continue Program coverage under COBRA, when your COBRA coverage ends, you will receive another certificate of coverage from Dow. In addition, if you would like another certificate of coverage, you can request one at any time within the 24-month period after your Dow sponsored coverage ceases by writing to the Retiree Service Center, The Dow Chemical Company, Employee Development Center, Midland, Michigan, 48674.

You are required to inform Dow of any change in your Dependent's eligibility status as soon as possible, and no later than during the annual enrollment period. Dow will provide a certificate of coverage for your covered Dependents upon request. If Dow knows that coverage for your covered Dependent has terminated, it will provide a certificate of coverage for your covered Dependents.

Information Exchanged by the Program's Business Associates

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

Section 10. 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 Dependents, including all costs of collection such as attorneys' fees and court costs; and/or (3) prohibit you from enrolling in the Program. In addition, the Program and/or Dow may pursue civil and/or criminal action against you, or take other legal action. If you or your Dependent(s) are terminated from eligibility under any benefit plan sponsored by Dow or a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you and your Dependent(s) are not eligible for coverage under the Program.

Section 11. Ending Coverage

11.1 When Coverage Ends

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

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

When your Dependent is no longer eligible, or dies, update your enrollment information on the Dow Benefits web site or by contacting the Retiree Service Center within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. If you qualify for a reduction in premium, the premium will be reduced effective as of the date your updated enrollment information is processed. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

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

- elects COBRA (See *Section 11.2 COBRA Continuation Coverage)*;
- may continue to participate in accordance with or *Section 4.3 Medicare Part D* because you lost coverage on account of enrolling in Medicare after being on Medicaid; or
- is eligible to participate after your death in accordance with *Section 8. Survivor Benefits.*

11.2 COBRA Continuation Coverage

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

There may be other coverage options for you and your family and some of these options may cost less than COBRA continuation coverage. You could be eligible to buy coverage through the Health Insurance Marketplace and for a tax credit that lowers your monthly premiums. You should be able to see what your premium, deductibles, and out-of-pocket costs will be for coverage purchased through the Marketplace before you enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace (but enrolling in COBRA may affect your eligibility for a tax credit). Additionally, you may qualify for a special enrollment opportunity for another group health plan for

which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after the qualifying event.

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

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

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

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
(800) 344-0661

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

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

What is COBRA Continuation Coverage?

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

If you are the Spouse of Record of a Retiree, you 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 becomes enrolled in Medicare (Part A, Part B, or both); or
3. You become divorced or legally separated from your Spouse.

As explained under *Section 11.2 COBRA Continuation Coverage*, although federal COBRA requirements do not apply to Domestic Partners, the Program provides Domestic Partners of Record with comparable protection to Spouses of Record for the qualifying events described above.

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

1. The parent-Retiree dies;
2. The parent-Retiree enrolls in Medicare (Part A, Part B, or both);

3. The parents become divorced or legally separated; or
4. The child stops being eligible for coverage under the Program as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in you losing coverage, you are a qualified beneficiary with respect to the bankruptcy. Your Spouse of Record, Surviving Spouse of Record, and Dependent Children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?

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

IMPORTANT: You Must Give Notice of Some Qualifying Events

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

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

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

If the qualifying event is a Dependent Child's loss of eligibility for coverage under a Plan, you must complete a Change in Status form that may be obtained from the Dow Benefits web site or by requesting one from the Retiree Service Center. In addition, you must complete a Dependent Qualifying Event letter, which may be obtained by requesting one 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 the notice is not provided to the Plan Administrator within the time required, any Spouse of Record/Domestic Partner of Record or Dependent Child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

How is COBRA Coverage Provided?

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

continuation coverage on behalf of your Spouse of Record, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

Continuation coverage terminates before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Patient Protection and Affordable Care Act); (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees or retirees. Continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

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

How Much Does COBRA Continuation Coverage Cost?

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

First Payment of Continuation Coverage

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

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

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

Periodic Payments for Continuation Coverage

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

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

Grace Periods for Periodic Payments

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate Recipients under QMCSOs

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

If You Have Questions

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

Keep the Program Informed of Address Changes

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

Section 12. Subrogation

As used in this Section 12, these terms have the following meaning:

- "Covered Person" means a Participant (including a Retiree) or a Dependent, the parents and legal guardians of a Participant or Dependent who is a minor, and the heirs, administrators, and executors of a Participant's or Dependent'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.

12.1 The Program's Entitlement to Reimbursement

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

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

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

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

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

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

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

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

12.2 Your Responsibilities

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

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

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

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

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

12.3 Jurisdiction

For purposes of this Section 12, by accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Program may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Section 13. Your Legal Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Program, including collective bargaining agreements (if applicable), the Plan Document, and the latest annual report 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, 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 11.2 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 18. 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 Aetna. For the contact information for the Plan Administrator and for Aetna, 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 14. Plan Administrator's Discretion

The Plan Administrators are the Vice President, Human Resources Center of Expertise; Global Benefits Director; Associate Director of North America Benefits; and North America Health and Welfare Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plans, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 26. Claims Procedures*.

Section 15. Plan Document

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

Section 16. 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 17. Dow's Right to Terminate or Amend the Program

The Dow Chemical Company reserves the right to amend, modify or terminate the Program and any or all of the Plans (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 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 18. Litigation and Class Action Lawsuits

18.1 Litigation

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

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

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

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

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

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

18.2 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 19. Incompetent and Deceased Participants

If the Administrator determines that you or your Dependent is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan, the Administrator may make benefit payments to the court-appointed legal guardian for you or your Dependent, to an individual who has become the legal guardian for you or your Dependent by operation of state law, or to another individual whom the Administrator determines is the appropriate person to receive such benefits on behalf of you or your Dependent.

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

Section 20. 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 Retiree, Participant, Dependent, beneficiary, claimant, or other person;
- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and
- no Retiree, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his Advisors with respect to whom a privilege applies, unless mandated by a court order.

Section 21. 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 22. 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 23. Funding

The Company shares the premium costs with the Participants. Participant contributions are either deducted from pension benefits or paid separately by the Participant. The Company's contribution to the premiums is limited to the contribution limits established in April 1994, and amended in July 2001, unless adjusted by the Company, as described in *Section 7.1 Retiree Medical Budget (Maximum Dow Subsidy, or the "Premium Cap")*. Benefits are paid from the Company's general assets.

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

Section 24. Uncashed Checks

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

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

Section 25. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program or Plan were provided to, or on behalf of, a Participant, Dependent, 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, Dependent or other person under the Program may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant, Dependent 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/or Dependent 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 or Dependent 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 Dependent 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 Retiree or his estate.

Section 26. Claims Procedures

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

- A *Claim for Plan Benefits* is a Claim requesting that the 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 as to the amount a claimant must contribute towards the cost of coverage.

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation. See your Description of Benefits in Appendix A for procedures governing Claims for Plan Benefits. See *Section 26.4 How to File a Claim for an Eligibility Determination*, below, for procedures for Claims for an Eligibility Determination.

26.1 Deadline to File a Claim

All Claims must be filed 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.

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

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

- *Claims for Plan Benefits.* The Initial Claims Reviewer and the Appeals Administrator is Aetna.
- *Claims for an Eligibility Determination*. The Initial Claims Reviewer is the North America Health and Welfare Plans Leader, and the Appeals Administrators are the Global Benefits Director and the Associate Director of North America Benefits.

Authority of Claims Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. However, the Claims Administrators' determinations are subject to the interpretation of the Plan Document made by the Plan Administrator. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Program under Section 502 of the Employee Retirement Income Security Act (ERISA) in federal court, provided you complete the claims procedures described in this *Section 26. Claims Procedures* (or the Claims

Administrator fails to timely respond to your claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *Section 18. Litigation and Class Action Lawsuits* for the deadline for filing a lawsuit.

26.3 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim on behalf of a Participant. The Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program. As described in the Description of Benefits (Appendix A of this SPD), in the case of a Claim for Plan Benefits that is an Urgent Care Claim, a health care professional with knowledge of your condition also may act as your authorized representative.

26.4 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

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

- The name of the Retiree and the name of the person (Retiree, Dependent, Survivor, as applicable) who is requesting the eligibility determination,
- The benefit plan for which the eligibility determination is being requested (The Dow Chemical Company Retiree Medical Care Program),
- If the eligibility determination is being requested for the Retiree's dependent:
  - a description of the relationship of the dependent to the Retiree (e.g., Spouse/Domestic Partner of record, Dependent Child, etc.);
  - documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility Determinations must be sent to:

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Initial Claims Reviewer for The Dow Chemical Company Retiree Medical Care Program (Claim for Eligibility Determination)

Initial Determination

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

If the Initial Claims Reviewer denies the Claim, the written notification of the Claims decision will state the reason(s) why the Claim was denied and refer to the pertinent Program provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer needed

additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

Appealing the Initial Determination

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

- the name of the Retiree and the name of the person (Retiree, Dependent, Survivor, as applicable) who is appealing the Administrator's decision
- the name of the Plan (The Dow Chemical Company Retiree Medical Care Program),
- reference to the initial determination, and
- an explanation of the reason why you are appealing the initial determination.

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

Associate Director of North America Benefits or the Global Benefits Director
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Appeals Administrator for The Dow Chemical Company Retiree Medical Care Program (Claim for Eligibility Determination)

You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You also may request that the Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

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

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

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

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

Section 27. Tax Consequences of Coverage and Benefits

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

Section 28. No Assignment of Benefits

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

Section 29. Definitions of Terms

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

Appeals Administrator:
The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is Aetna. The Appeals Administrators with respect to reviewing an adverse Claim for an Eligibility Determination are the Associate Director of North America Benefits and the Global Benefits Director.

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

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

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

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

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

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

Company:
The Dow Chemical Company.

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

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

- Your birth or legally adopted child; or
- Your Spouse of Record's or Domestic Partner of Record's natural or adopted child; or
- A child for whom you or your Spouse of Record/Domestic Partner of Record 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. "Legally relinquished all of their parental rights" means that the biological parents permanently do not have the:
  - authority to consent to the child's marriage or adoption, or
  - authority to enlist the child in the armed forces of the U.S.;
  - right to the child's services and earnings; and
  - power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

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

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

DEPP component:
The DEPP component of the Dow Employees' Pension Plan.

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

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

1. the two people have lived together for at least twelve (12) consecutive months immediately prior to receiving coverage under the Program,
2. the two people are not Married to other persons and were not Married to other persons at any time during the twelve (12) consecutive month period preceding coverage under the Program,
3. the two people are and were, during the twelve (12) consecutive month period preceding coverage under the Program, each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely,

4. both people are legally competent and able to enter into a contract,
5. the two people are not related to each other in a way which would prohibit legal Marriage,
6. in entering the relationship with each other, neither of the two people is acting fraudulently or under duress,
7. during the twelve (12) month period preceding coverage under the Program, the two people have been and are financially interdependent with each other, and
8. both people signed a statement acceptable to the Plan Administrator indicating the above requirements have been met and provided it to the Plan Administrator.

b. Requirements of paragraph b (Civil Union Test):
   1. evidence satisfactory to the Plan Administrator is provided that the two people are registered as domestic partners, or partners in a civil union in a state or municipality or country that legally recognizes such domestic partnerships or civil unions, and
   2. both people signed a statement acceptable to the Plan Administrator and provided it to the Plan Administrator.

Domestic Partner of Record:
A person who was eligible for Domestic Partner benefits under the Program on December 31, 2002, and continues to be the former Employee's Domestic Partner. In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to December 31, 2002.

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

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

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

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

Employee:
A person who:

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

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

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement between the Participating Employer and another business, such as a leasing organization;
2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;
3. an individual 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 Service:
You are deemed to have Full Service if you Retired before January 1, 1993, with 10 or more years of Service. Different rules apply if you Retired after December 31, 1992. You are not eligible for coverage under the Old or New Plan if you Retired on or after January 1, 1993. Contact the Retiree Service Center for information about the retiree medical coverage that might apply to you.

HIPAA:
The Health Insurance Portability and Accountability Act.

HMO:
Health Maintenance Organization.

Hourly Employee:
An Employee who is represented by a collective bargaining unit that is recognized by the Participating Employer. "Bargained-for Employee" and "Hourly Employee" have the same meaning.

Initial Claims Reviewer:
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is Aetna. The Initial Claims Reviewer with respect to deciding a Claim for an Eligibility Determination is the North America Health and Welfare Plans Leader.

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.

Married or Marriage:
A civil contract between two individuals who have the legal capacity to marry and that is formalized by a marriage license. Whether a person is "Married" for purposes of the Program shall be determined in accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue

Service and the Department of Labor. For periods before September 16, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Program then in effect. The Program does not recognize common law marriages except that:

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

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

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

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

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

Participant:
A Retiree, Survivor or Dependent who participates in a Plan under the Program because he meets the eligibility criteria of 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.

Plan:
Either the Basic/Supplemental (Old) Plan or the Comprehensive (New) Plan applicable to Retirees, whichever is applicable in the context of the sentence. The Basic/Supplemental (Old) Plan and Comprehensive (New) Plan applicable to Retirees are two of several plans that are part of the Program.

Plan Administrator:
Each of the Vice President, Human Resources Center of Expertise; the Global Benefits Director; the Associate Director of North America Benefits; the North America Health and Welfare Plans Leader; and such other person, group of persons or entity which may be designated by The Dow Chemical Company in accordance with the Plan Document.

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

Program:
The Dow Chemical Company Retiree Medical Care Program.

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

Retire or Retirement:
"Retire" or "Retirement" means when an active Employee who is age 50 or older with at least 10 years of Service terminates employment with a Participating Employer to become a "retiree" under the terms of the Dow Employees' Pension Plan (formerly known as the Employee Retirement Plan).

Retiree:
A "Retiree" is an Employee who has met the requirements of Retirement.

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

Retiree Medical Participant:
This term is used in the context of explaining the Retiree Medical Budget in *Section 7. Premiums and Premium Cap*. It means a Retiree, 60 Point or 65 Point Retiree Medical Severance Plan Participant, an LTD Participant, or a Survivor who is a participant in a plan (other than the International Medical and Dental Plan) offered under The Dow Chemical Company Insured Health Program or is a Participant in the Program.

Salaried:
Not represented by a collective bargaining unit.

Spouse:
A person who is Married to an Employee or Retiree. See the definition of Marriage for further details. With regard to a Retiree, your Spouse must be your Spouse of Record in order to be eligible for coverage under the Program.

Spouse of Record:
The person who was Married to the former Employee who was eligible for coverage under the Program on December 31, 2002, and continues to be Married to the former Employee.

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

Summary Plan Description ("SPD"):
The summary plan description for the Program's Basic/Supplemental (Old) Plan and Comprehensive (New) Plan applicable to Retirees, including its appendices. This SPD is an integral part of the Plan Document.

Surviving Spouse/Domestic Partner:
The widowed Spouse/Domestic Partner of an active Employee who was eligible to participate in The Dow Chemical Company Medical Care Program at the time of death of the Employee.

Surviving Spouse of Record/Domestic Partner of Record:
The widowed Dependent Spouse of Record/Domestic Partner of Record of a Retiree who participated in the Program, if such Spouse of Record/Domestic Partner of Record was an eligible Dependent at the time of the death of such Retiree; provided, that the deceased was a vested participant of the Dow Employees' Pension Plan.

Survivor:
A Surviving Spouse or Surviving Domestic Partner or Surviving Spouse of Record or Surviving Domestic Partner of Record.

Termination of Domestic Partnership:
In order to meet the definition of "Termination of Domestic Partnership," you must complete and sign a statement satisfactory to the Plan Administrator that states, among other things, that the Domestic Partnership is terminated. A Termination of Domestic Partnership is not effective with respect to the Program until the signed statement has been received by the Plan Administrator.

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

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

Section 30. For More Information

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

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Basic/Supplemental Plan ("Old Plan") and Comprehensive Plan ("New Plan"), offered under The Dow Chemical Company Retiree Medical Care Program (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 Plan at any time in its sole discretion.

The Plan Document can be made available for your review upon written request to the Plan Administrator (whose contact information is listed in *Section 1. ERISA Information*). The SPD and the Program do not constitute a contract of employment. Your employer retains the right to terminate your employment or

otherwise deal with your employment as if this SPD and the Program had never existed.

APPENDIX A. Description of Benefits

Plan Description for the Basic/Supplemental (Old) Plan

Plan Description for the Comprehensive (New) Plan

APPENDIX B. Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

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

Effective Date of Notice: August 20, 2013

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

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

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

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

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor[2] for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expense or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

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

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

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

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

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

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

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

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

Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be obtained before any of the plans listed in the footnote[3] will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

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

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

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

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

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

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

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

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

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

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

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

Prohibited Uses and Disclosures

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

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

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

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

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Requests to restrict uses and disclosures of your PHI should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674.

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

Right to Inspect and Copy PHI

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

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

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

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

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674.

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

Right to Request Amendment of PHI

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

You or your personal representative will be required to complete a form to request an amendment of PHI in a designated record set. Requests for amendment of PHI in a designated record set should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674.

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

Right to Receive an Accounting of PHI Disclosures

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

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

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

You or your personal representative will be required to complete a form to request an accounting of PHI disclosures. Requests for an accounting of PHI

disclosures should be made to the following person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following person: Health Insurance Portability and Accountability Act (HIPAA) Privacy Official for ERISA Health Plans; Employee Development Center, Midland, MI 48674.

A Note About Personal Representatives

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

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

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

Section 3. The Plan's Duties

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

This notice is effective beginning August 20, 2013 and the Plan is required to comply with the terms of this notice on and after that date. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to and after that date. If a privacy practice is changed, a revised version of this notice may be provided to those for whom the Plan still maintains PHI. The notices will be provided in the Choices enrollment brochures and updated versions of the summary plan descriptions or other appropriate means of communication.

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

Minimum Necessary Standard

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

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

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

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

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following

person: Privacy Official; The Dow Chemical Company Health Plans; Employee Development Center, Midland, MI 48674.

Section 4. Conclusion

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

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

Applicable to Plan Year 2014

The Dow Chemical Company Retiree Medical Care Program does provide Creditable Coverage for prescription drugs for the following plan:

- Basic/Supplemental (Old) Plan
- Comprehensive (New) Plan

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The Dow Chemical Company has determined that the prescription drug coverage offered by the Retiree Old and New Plans is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Dow coverage, you may not re-enroll in either the Old Plan or the New Plan unless you were enrolled in a Dow-approved Medicare Advantage Plan that provides prescription drug coverage.

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

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

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

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

Contact the Retiree Service Center at (800) 344-0661. **NOTE:** You'll get this notice each year. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	Fall, 2013
Name of Entity/Sender:	The Dow Chemical Company
Contact--Position/Office:	U.S. Benefits Center
Address:	Employee Development Center Midland, MI 48674
Phone Number:	(800)-344-0661

APPENDIX D. CHIP Premium Assistance Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><td>IDAHO – Medicaid</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084</td></tr>
</table>

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

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

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