Summary Plan Description "Wrapper" for:

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

Union Carbide Corporation
Insured Health Program

(ERISA Plan #555)

APPLICABLE TO ELIGIBLE RETIREES

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Effective January 1, 2014 and thereafter until superseded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 # 318-60937

THE DOW CHEMICAL COMPANY
ADOPTION OF SUMMARY PLAN DESCRIPTIONS

WHEREAS, The Union Carbide Corporation ("UCC") sponsors the Union Carbide Corporation Retiree Medical Care Program (the "Retiree Medical Program"), and the Union Carbide Corporation Retiree Insured Health Program (the "Insured Health Program" and together with the Retiree Medical Program, the "Programs");

WHEREAS, UCC offers 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 Medicare Supplement 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, UCC 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, UCC wishes to adopt revised Summary Plan Descriptions for the Plans.

NOW, THEREFORE, BE IT RESOLVED, UCC 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:

Union Carbide Corporation
Retiree Medical Care Program's

Map Plus Option 1 Low Deductible Plan
MAP Plus Option 2 High Deductible Plan
Medicare Supplement Plan ("MSP")

(ERISA Plan #540)

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Effective January 1, 2014 and thereafter until superseded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:

Union Carbide Corporation Insured Health Program (ERISA Plan #555)

Applicable to Eligible Retirees

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Effective January 1, 2014 and thereafter until superseded

Summary Plan Description for:

Union Carbide Corporation
Retiree Medical Program

Self-Funded HMO Plans

(ERISA Plan #540)

Applicable to 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. Hamler

Reviewed by Officer of UCC

JMS _____
Ignacio Molina

Dated: October 31, 2014

Table of Contents

Section 1. ERISA Information

Summary Plan Description Wrapper for Union Carbide Corporation Insured Health Program *Applicable to Eligible Retirees*	
Type of Plan	Group health plan
Type of Plan Administration	Benefits provided under an insured arrangement with the HMO or insurer of your Plan
Plan Sponsor	Union Carbide Corporation Employee Development Center Midland, Michigan 48674
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	13-1421730
Plan Number	555
Retiree Service Center	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800) 344-0661
Claims Administrators for Claims for Plan Benefits:	*To submit a Claim for Plan Benefits or to appeal a denied Claim for Plan Benefits* : Contact the applicable Plan HMO or insurer. See the materials provided by the HMO or insured health plan.

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	The applicable Plan at the address provided by the HMO or insurer. or General Counsel Union Carbide Corporation 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
HMO Network Manager	Secova is the HMO Network Manager for HMOs offered to Retirees and their Dependents. Secova, Inc. 535 Anton Boulevard, Suite 900 Costa Mesa, California 92626 (800) 7DOWDOW or (800) 858-4347
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.

Funding	Union Carbide and Participating Employers share the premium costs with Retirees. The Company's share of the premium costs is limited to the retiree medical budget established in January 2000 and July 2003, unless adjusted by the Company. These contribution limits are described in *Section 8. Premiums and Premium Cap*. Benefits are underwritten by the applicable Plan. The applicable HMO or insurer is liable to pay the benefits, not any Participating Employer, UCC, or Dow. 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 may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.
Retiree-Only Coverage	The Union Carbide Corporation Insured Health Program does not cover any active employees. Accordingly, Plan coverage provided under the Program is not subject to (i) the special enrollment, pre-existing condition, and nondiscrimination requirements (other than those relating to GINA) of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); (ii) the Women's Health and Cancer Rights Act of 1998, as amended, with respect to post-mastectomy reconstructive surgery; (iii) the Mental Health Parity Act of 1996, as amended, or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, with respect to mental health benefits; or (iv) the coverage mandates and prohibitions for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA").

Section 2. Summary Plan Description "Wrapper"

This is the Summary Plan Description "Wrapper" ("SPD Wrapper") for Health Maintenance Organizations ("HMOs") and insured health plans that are offered through the Union Carbide Corporation Insured Health Program (the "Program"), as applicable to eligible Retirees, 60 Point Retiree Medical Severance Plan Participants, LTD Participants, and certain other former Employees. The HMOs and insured plans offered by the Program are listed each Fall in the annual enrollment materials. In this SPD Wrapper, the HMOs and insured plans offered by the Program are referred to collectively as the "Plans" and individually as a "Plan."

This SPD Wrapper addresses:

- ERISA Information
- Eligibility for Coverage
- Enrollment

- Mid-Year Election Changes
- Premiums
- Survivor Benefits
- Disclosures
- Fraud Against the Program
- Ending Coverage and Your Rights under COBRA
- Your Legal Rights under ERISA
- Plan Administrator's Discretion
- Plan Document (scrivener's error)
- Welfare Benefits
- UCC's Right to Terminate or Amend the Program
- Disposition of Plan Assets if the Program is Terminated
- Litigation and Class Action Lawsuits
- Incompetent and Deceased Participants
- Privilege
- Waiver and Notices
- Funding
- Payment of Unauthorized Benefits
- Filing and Appealing Claims for an Eligibility Determination

This SPD Wrapper does not include all of the information about benefits under the Plans. Further information can be found in the Plan Document for the Program, as well as in materials provided to you by the applicable Plan. The materials provided by the Plans address the following:

- Benefits covered under the applicable Plan and the coverage levels
- Terms and Conditions for benefits coverage under the applicable Plan
- Copays, deductibles, out of pocket maximums and coverage limitations
- Filing and appealing Claims for Plan Benefits
- Precertification or preauthorization requirements
- In-network and out-of-network provisions, if any
- Primary care physician requirements, if any
- Any other provisions of the applicable Plan
- HIPAA notice of privacy practices

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

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 Wrapper as the "Plan

Document." If there is any inconsistency between this SPD Wrapper and the Plan Document, the Plan Document shall govern. You may request a copy of the Plan Document from the Plan Administrator at the contact information in *Section 1. ERISA Information*.

Union Carbide Corporation reserves the right to amend, modify or terminate the Program (and/or its inclusion or exclusion of any HMO or insured plan) at any time in its sole discretion.

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

The provisions of this SPD Wrapper apply only to Plans offered through the Program. For information about other Dow- or UCC-sponsored plans for which you may be eligible, check www.dowfriends.com or call the Retiree Service Center at (800) 344-0661.

Capitalized words in this SPD are defined in the Plan Document, in *Section 29. Definitions of Terms*, or in the materials provided by the Plans. "UCC" and "Company" refer to Union Carbide Corporation. "Dow" refers to The Dow Chemical Company. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Section 3. About HMOs and Insured Plans

3.1 How HMOs Operate

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

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

Generally, when you join an HMO, you select a Primary Care Physician (PCP) from the HMO staff. You agree to use the HMO's facilities and staff, or those under contract to the HMO, instead of obtaining services from physicians, specialists or facilities not affiliated with the HMO.

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

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

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

Any disagreement between you and the HMO becomes a matter to which you and the HMO should respond. For example, if you disagree with the HMO over a settlement of a Claim, or have any questions concerning a physician referral, you should follow the review and appeals procedures of that HMO. Any charge not paid by the HMO becomes your responsibility – not Dow's or UCC's. If an HMO fails to pay

a charge directly to a health care provider or fails to provide coverage for an expense you feel should be covered, the disagreement should be settled between you and the HMO.

Under certain circumstances, you may continue coverage for you and your Dependents for a limited time under the rules established in the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See *Section 12.2 COBRA Continuation Coverage* for details, or contact the Dow Retiree Service for details about COBRA. For details about converting your HMO coverage to an individual policy, contact your HMO (at the contact information listed in the materials it provides you) or Secova (at the contact information listed in *Section 3.4 Secova, the HMO Network Manager*).

3.2 Dow, Union Carbide and HMOs and Insured Plans

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

3.3 Information that Your HMO Should Provide You

Each HMO or insurer will supply you, upon written request, written materials concerning:

- the nature of services provided under the Plan;
- conditions pertaining to eligibility to receive such services, other than general conditions pertaining to eligibility required by UCC described in this SPD Wrapper;
- the circumstances under which services can be denied;
- the procedures to be followed in obtaining such services and the procedures available for the review of the Claims for Plan Benefits that are denied in whole or in part.

3.4 Secova, the HMO Network Manager

The Company has contracted with Secova, Inc. to serve as UCC's HMO Network Manager and to manage the HMOs that participate in the Program. If you would like more information regarding the availability of HMOs in your area, or do not know how to contact your HMO, contact Secova at (800) 7DOWDOW. Secova will also assist you in obtaining HMO materials if you need help getting them from the HMO.

3.5 Medicare Advantage Plans

The Plans offered under the Program that are available to those who are eligible for Medicare are HMOs or insured plans that have been approved by the government as "Medicare Advantage Plans with Prescription Drug Coverage" and are "Medicare Advantage Plans." If enrolling in a Medicare Advantage Plan, you must be enrolled in Medicare Parts A and B.

3.6 Grandfathered HMOs

UCC believes that certain HMOs offered under the Program may be "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA), commonly referred to as federal health care reform. Contact the HMO directly or refer to the materials provided by your HMO if you want to know whether the HMO plan is grandfathered.

Being a grandfathered health plan means that the plan may not include certain consumer protections of PPACA. Questions regarding which protections apply and which protections do not apply to a

grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Retiree Service Center. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa.

Section 4. Eligibility

As explained in this section of the SPD, the Program provides coverage for certain Retirees, disabled individuals, and other former Employees, as well as certain dependents. Survivor eligibility is summarized in *Section 9. Survivor Benefits*.

4.1 Plan Availability

Besides meeting the eligibility criteria described in this SPD Wrapper, in order to participate in a particular Plan, you must be located where the Plan is available. If you move and thereby cease to be eligible for your Plan, you may change your enrollment. See *Section 6.6 If You Move out of the Plan Covered Location during the Plan Year*. Note that the Aetna Medicare Advantage PPO available nationwide.

In addition, some Plans do not provide coverage to Medicare eligible individuals.

4.2 Eligibility for Retirees and Certain Disabled Individuals

Retiree Eligibility

The Program is applicable to eligible Retirees. "Retiree" is defined in the Plan Document and summarized in *Section 29. Definitions of Terms*.

The Program is not applicable to you if:

- *You retired under the terms of the Dow Employees' Pension Plan*. Instead, refer to the summary plan description for The Dow Chemical Company Retiree Medical Care Program.
- *You retired under the terms of the Rohm and Haas Company Retirement Plan or the Morton International, Inc. Pension Plan for Collectively Bargained For Employees*. Instead, refer to the summary plan description for the Rohm and Haas Retiree Medical Care Program, which is part of the Rohm and Haas Group Health Plan under the Rohm and Haas Company Health and Welfare Plan.

If you are a Retiree, you are eligible for coverage under the Program if you meet all of the following requirements:

- You are age 50 or older and have 10 or more years of Service (as defined in the Plan Document and summarized in *Section 29. Definitions of Terms*);
- You were hired by a Dow Entity before January 1, 2008[1];
- Your employer was a Dow Entity before January 1, 2008, and continues to be a Dow Entity at the time you Retire;

[1] If your employment with a Participating Employer terminated prior to January 1, 2008 (referred to as your "pre-January 1, 2008 termination date"), and you are subsequently re-hired by a Dow Entity, your first hire-date will be recognized by the Plan only if (1) you become a participant of the UCEPP component of the Union Carbide Employees' Pension Plan after your re-hire date, or (2) you were eligible for coverage under the Program as of your pre-January 1, 2008 termination date because you were a Retiree, or a 60 Point Retiree Medical Severance Plan Participant, and after re-hire, you did not become a participant of the UCEPP component of the Union Carbide Employees' Pension Plan, but instead became a participant of the Personal Pension Account component of the Union Carbide Employees' Pension Plan.

- You were eligible as an active Employee for coverage under The Dow Chemical Company Medical Care Program immediately before your Retirement;
- You are not eligible for coverage as an employee or retiree under another medical program or retiree medical support program sponsored by Union Carbide or Dow or any entity that is 50% or more owned by Dow (other than The Dow Chemical Company Retirement Health Care Assistance Plan; the Union Carbide Corporation Retiree Medical Care Program; and, for former employees of Americas Styrenics LLC, the Americas Styrenics LLC Retiree Reimbursement Account Plan, but only if you never elect to participate in that plan after terminating employment with Americas Styrenics LLC);
- You are not precluded from eligibility under a provision in the Plan Document; and
- If you were a Bargained-for Employee, coverage has been extended to your bargaining unit.

If you were hired by a Dow Entity on or after February 6, 2001, and you are Eligible for Medicare, you are NOT eligible for coverage under the Program.

Certain Disabled Individuals

Certain disabled individuals are eligible for coverage under the Program. In general, to the extent that you are eligible for coverage under the Program as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as a Retiree. Unless the context requires otherwise, references to "Retiree" in this SPD include all Participants whose eligibility is described in this Section 4.2 of the SPD.

Long-Term Disability Participants

If you are eligible to participate in the Union Carbide Employees' Pension Plan and you have been approved to receive benefit payments from The Dow Chemical Company Long Term Disability Program ("LTD"), you are eligible for coverage under the Program under the following circumstances:

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

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

  If you were hired by Dow or Union Carbide prior to January 1, 2008 and you have ten (10) or more years of Service, you are eligible for medical coverage until you are no longer eligible to receive payments from LTD.

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

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

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

You are ***not*** eligible for the coverage under the Program or under the Union Carbide Retiree Medical Care Program if you receive benefit payments from the LTD and you are a vested participant of the Dow Employees' Pension Plan or the Rohm and Haas Company Retirement Plan. Instead, refer to the

summary plan descriptions for The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program, or the Rohm and Haas Company Health and Welfare Plan, whichever is applicable.

Disability Retirees under Union Carbide Employees' Pension Plan

If you have been approved for disability retirement benefits under the UCEPP component of the Union Carbide Employees' Pension Plan on or after February 7, 2003, you may also be eligible for coverage under the Program. Eligibility under this provision ends if you no longer have "disability retiree" status under the UCEPP component of the Union Carbide Employees' Pension Plan.

Currently, if the effective date of your disability retirement under the UCEPP component of the Union Carbide Employees' Pension Plan is on or after February 7, 2003, but before January 1, 2006, UCC pays the full premium. Effective January 1, 2006, if the effective date of your disability retirement status under the UCEPP component of the Union Carbide Employees' Pension Plan is on or after January 1, 2006, UCC provides you a premium subsidy at the Full Service level, regardless of your actual years of service. You are required to pay a premium based on the Retiree Medical Support Schedule and the Retiree Medical Budget. See *Section 8. Premiums and Premium Cap*.

If you are not eligible for Medicare, your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level that you had when you were an active Employee. If you are eligible for Medicare, your coverage will be under the MSP. Refer to the summary plan description for the UCC Retiree Medical Care Program for more information about enrolling in MSP.

Certain Other Former Employees

60 Point Retiree Medical Severance Plan Participants

If you meet the definition of "60 Point Retiree Medical Severance Plan Participant" in the Plan Document, you are eligible to participate in the Program, but only if you are a vested participant of the Union Carbide Employees' Pension Plan with a benefit under the UCEPP Component. If you are a 60 Point Retiree Medical Severance Plan Participant, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as a Retiree.

Mergers, Acquisitions and Other Special Situations

Special eligibility rules might apply if you were a part of a merger or acquisition, or a joint venture or other special business arrangement or situation. These special rules are provided in Article III of the Plan Document. Contact the Retiree Service Center for more information.

Ineligibility of Universal Oil Products Employees

Notwithstanding anything in this SPD or the Plan Document to the contrary, an Employee who terminated employment with a Participating Employer at age 50 or older with 10 or more years of Service, and subsequently began working for Universal Oil Products ("UOP") within 10 days of such termination of employment of the Participating Employer, is NOT eligible for coverage under the Program if:

- such former Employee subsequently terminates employment with UOP;
- at the time of such termination of employment from UOP, such former Employee is eligible for retiree medical coverage under a program sponsored by UOP; and
- UOP recognizes the former Employee's service with Union Carbide for purposes of determining eligibility for coverage under the retiree medical program sponsored by UOP.

Ineligibility if Eligible Under any Other UCC or Dow Medical Program

You are not eligible for coverage under the Program if you are eligible for coverage under any other Union Carbide or Dow-sponsored medical program that is available to Retired Employees, their Dependents, Surviving Spouses/Domestic Partners, or Surviving Spouses of Record/Domestic Partners of Record (other than The Dow Chemical Company Retirement Health Care Assistance Plan; the plans offered under the Union Carbide Corporation Retiree Medical Care Program; and, for former employees of Americas Styrenics LLC, the Americas Styrenics LLC Retiree Reimbursement Account Plan, but only if you never elect to participate in that plan after terminating employment with Americas Styrenics).

4.3 Dependent Eligibility

Eligible Retirees (and other Participants eligible for coverage under Section 4.2 of this SPD) 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 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 your Retirement. If you marry, remarry or enter into a new Domestic Partnership after Retirement (or after otherwise meeting the eligibility requirements under Section 4.2 of this SPD), your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow-sponsored retiree medical program. However:

- if you Retired and remarried, or filed a Domestic Partner Statement satisfactory to the Plan Administrator, before December 31, 2002, you may continue to cover that Spouse of Record/Domestic Partner of Record so long as you remain Married or in the Domestic Partnership; and
- if you Retire with a Domestic Partner of Record and later marry the Domestic Partner of Record, you may continue to cover the Domestic Partner of Record as a Spouse of Record so long as you remain Married.

Similarly, as explained below, if you marry, remarry or enter into a new Domestic Partnership after Retirement and neither of the exceptions described in the two bullet points above apply, your new Spouse's or Domestic Partner's children (e.g., your step-children) who are not your birth or legally adopted children are not generally eligible for coverage under 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.[2] 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 UCC, 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.

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

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

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 or in Medicare 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 11. 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's/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 the materials provided by your Plan).

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

You should consider carefully whether it is advantageous to enroll your Spouse of Record/Domestic Partner of Record as a Dependent under the 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 UCC and 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/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.

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 UCC retiree medical coverage prior to March 1, 2013, and remains continuously covered under UCC 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 12.2 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 (or other individual eligible for coverage under Section 4.2 of this SPD) has a "qualified medical

child support order" for that child. A Qualified Medical Child Support Order ("QMCSO") is a court order that meets the Program's requirements to provide a child the right to be covered under 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 (or other individual eligible for coverage under Section 4.2 of this SPD) 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 (or other Participant) must provide medical coverage;
- A reasonable description of the type of coverage to be provided to the child; and
- The period for which the coverage is to be provided (within the Program's rules).

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

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

4.4 Special Eligibility Rules if You or Your Dependents are Eligible for Medicare

Eligibility Once You Are Eligible for Medicare

If you were hired on or after February 6, 2001, you are not eligible to participate in the Program once you become Eligible for Medicare.[3] See *Section 5. Medicare* for more information on what you must do when you become Medicare-eligible.

Dependent Eligibility Once You or Your Dependent Is Eligible for Medicare

If you lose eligibility for coverage under the Program because you become Eligible for Medicare:

- Your Spouse of Record/Domestic Partner of Record may continue coverage under the Program until he or she becomes eligible for Medicare. To do so, your Spouse of Record/Domestic Partner of Record must pay 102% of the full, unsubsidized cost to insure under the Plan based on your Spouse of Record/Domestic Partner of Record's age.
- Dependent Children (if any) may continue coverage under the Program as long as your Spouse of Record/ Domestic Partner of Record continues to pay 102% of the full, unsubsidized cost to insure. To continue coverage for Dependent Children, your Spouse of Record/Domestic Partner of Record must pay a corresponding rate.

Your Spouse of Record/Domestic Partner of Record will lose eligibility for coverage under the Plan once he or she becomes eligible for Medicare, regardless of whether you are eligible for Medicare already.

[3] In general, for purposes of this SPD, the date you were *hired* is the date you first became eligible for coverage as an active Employee under The Dow Chemical Company Medical Care Program. For example, this may be the date your Participating Employer provided coverage for employees classified as less-than-full-time Employees (allowing you to participate in The Dow Chemical Company Medical Care Program), or the date you we classified as having full-time status and therefore became eligible for coverage under The Dow Chemical Company Medical Care Program.

Dependent Children may continue coverage only as long as either you or your Spouse of Record/Domestic Partner of Record is still eligible for coverage under the Program.

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) that is not sponsored by the Company or a Medicare prescription drug plan (Medicare Part D), you are ***NOT*** eligible for coverage under the Program. You cannot be enrolled in **both** the Program and a Medicare Advantage Plan 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 Medicare prescription drug coverage at the same time.

4.5 International Medical and Dental Plan Exclusion

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

4.6 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 26.4 How to File a Claim for an Eligibility Determination*.

Section 5. Medicare

5.1 Medicare Eligibility May Result in Changes or Loss in Coverage under the Program

If you were hired on or after February 6, 2001, you are not eligible to participate in the Program once you become Eligible for Medicare. In addition – regardless of your hire date – you may become ineligible for your Plan when you become Eligible for Medicare.

If You Were Hired On or After February 6, 2001

If you were hired on or after February 6, 2001, you are not eligible to participate in any medical plan offered under either the Program or the Union Carbide Retiree Medical Care Program once you become Eligible for Medicare. You should enroll in Medicare Parts A and B, or a Medicare Advantage Plan. However, you are ***not*** eligible to enroll in a Medicare Advantage Plan offered under the Program. You should also consider enrolling in Medicare Part D. Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.

If You Are Enrolled in a Plan that Does Not Permit Medicare-Eligible Individuals

Even if you are eligible to continue UCC retiree medical coverage after you become Eligible for Medicare (this applies to you only if you were hired before February 6, 2001), some Plans do not permit individuals who are eligible for Medicare. In addition, some Plans do not permit individuals to enroll if one of their family members (i.e., one of the people in your coverage level) is eligible for Medicare.

If either of these restrictions applies to you, you will not be able to continue Plan coverage once you and/or your Dependent becomes Medicare-eligible. If you remain eligible for UCC coverage once you

are eligible for Medicare, you may switch to a different Plan that does accept Medicare, or you may switch to a UCC self-insured plan under the Union Carbide Retiree Medical Care Program, subject to the eligibility rules that apply to those plans.

5.2 Pre- Feb. 6, 2001 Hires: Requirement to Enroll in Medicare

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

In general, if you were hired before February 6, 2001 (or are subject to special provisions in the Plan Document permitting you to continue coverage after Medicare eligibility), and 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 a UCC medical 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 or you may also enroll in a UCC Medicare Advantage Plan.

Similarly, if your Spouse of Record/Domestic Partner of Record or your Dependent 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 a UCC medical plan.

Once enrolled in Medicare, you may be eligible for reduced premiums under the Program and you may need to enroll in a new plan. To do so, you must contact the Retiree Service Center promptly to inform Dow of the Medicare enrollment. If you do not inform Dow in a timely manner, you will be defaulted into the MSP A plan option and premiums may be adjusted retroactively to the correct amount back to January 1st of the current Plan Year.

If You Retire At or After You Reach Medicare Eligibility Age

- If you Retire (or become a 60 Point Retiree Medical Severance Plan Participant or LTD Participant) at 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 (or become a 60 Point Retiree Medical Severance Plan Participant or LTD Participant) 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 UCC Medicare Advantage Plan. A prerequisite to enrolling in a UCC 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 or any UCC plan 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.

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 day 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.

5.3 Switching from Program Coverage to a Self-Insured Plan if You Are Medicare-Eligible

Note: This rule applies only if you are eligible for coverage under the Program after you are Eligible for Medicare. As explained above, if you were hired on or after February 6, 2001, you are not eligible for coverage under the Program once you are Medicare-eligible. If you are not yet Eligible for Medicare, your ability to switch coverage other than at retirement or during annual enrollment is described in Section 7. Mid-Year Election Changes.

If you are Medicare-eligible and you are participating in a Plan under the Program, you may switch to a retiree medical plan under the Union Carbide Retiree Medical Care Program at any time, once you disenroll from the Plan. *To do so, you must meet the eligibility requirements of the applicable UCC self-insured retiree medical plan.* In addition, you will be eligible only for the MSP, and your participation in the MSP is subject to rules regarding the MSP option in which you may enroll. Refer to the summary plan description for the UCC Retiree Medical Care Program MSP.

Section 6. Enrollment

6.1 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. For

example, if you are enrolled in the Kaiser HMO, your Dependent may not be enrolled in Blue Care Network or one of the MAP Plus plans.

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

6.2 Enrolling at Retirement

To enroll for Program coverage upon your Retirement, enroll within 31 days after your Retirement on the Dow Benefits web site or by calling the Retiree Service Center. If you do not enroll yourself and/or your eligible Dependents within 31 days after Retirement, you and/or they will not be covered. You will not be eligible to enroll until the next annual enrollment period unless you have a special enrollment event or change in status that meets the consistency rules (see *Section 7. Mid-Year Election Changes*).

If you are enrolling your Spouse of Record/Domestic Partner of Record and/or Dependent Child(ren), you must provide proof of their eligibility within the timeframe requested by the Plan Administrator. Required documentation may include a Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers, or any other proof the Plan Administrator deems appropriate. If you do not provide proof of Dependent eligibility within the timeframe required by the Plan Administrator:

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 the date your proof of Dependent eligibility was required by the Plan Administrator.
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 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 11. Fraud Against the Program*.

6.3 Annual Enrollment

Annual enrollment is typically held during the last quarter of the year and is handled electronically. Subject to the eligibility rules and to the rules described in *Section 6.4 Re-enrolling After Waiving Coverage*, below, you may enroll for coverage, switch plans, or waive coverage at this time. If you wish to add a Dependent – either a Spouse of Record/Domestic Partner of Record or an eligible child – during annual enrollment, you must make sure that your coverage level is appropriate when you enroll.

Note: If you enroll or disenroll in a Medicare Advantage Plan, your enrollment or disenrollment must be approved by the Centers for Medicare and Medicaid Services ("CMS"), the government agency that administers Medicare. Your election to enroll or disenroll in a Medicare Advantage Plan offered by UCC is not effective until the Medicare Advantage Plan has received approval from CMS. Until such approval

by CMS is received by the Medicare Advantage Plan, the plan administrator of the UCC plan may enroll you in an alternative option.

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 11. 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 12.2 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.

6.4 Re-enrolling After Waiving Coverage

If at any time you waive coverage, and you subsequently would like to enroll for coverage under the Program, you may do so during annual enrollment, and your enrollment will be subject to the following rules:

- You may enroll in coverage under the Program only if you meet the eligibility requirements and--
  - You submit proof at the time of enrollment of other health coverage provided through another employer or former employer, or proof of private individual coverage;

- You submit proof of enrollment in Medicare Parts A and B or a Medicare Advantage Plan that provides prescription drug coverage; or
- You were not Eligible for Medicare and were covered under the MAP Plus Option 2 High Deductible Plan for the two preceding years.

- If you are not eligible to enroll in the Program, you might be able to enroll in one of the MAP Plus Plans offered under the Union Carbide Corporation Retiree Medical Care Program. You should refer to the applicable summary plan description or contact the Retiree Service Center for more information.

6.5 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.)

6.6 If You Move out of the Plan Covered Location during the Plan Year

If you move during the Plan Year and your Plan is not offered at your new location, you may switch your coverage to a Plan that is available at the new location or switch to one of UCC's self-insured retiree medical plans, subject to the eligibility requirements of those plans. If you want to continue receiving health coverage under a UCC-sponsored plan after you move, you must notify the Retiree Service Center within 90 days of your move. Your ability to switch coverage is subject to the rules in *Section 7. Mid-Year Election Changes*.

Section 7. 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 medical coverage level (e.g., enroll yourself or **add** a Dependent) mid-year only if you have a special enrollment event or 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 special enrollment events, the definition of "change in status" and the consistency rules, and exceptions to these rules, as well as the documentation required and deadlines for making a mid-year election change.

Note: Your ability to enroll yourself or your Dependent in the Plan pursuant to these mid-year election change rules is subject to the eligibility rules for the Plans, see *Section 4. Eligibility*, as well as rules that apply if you attempt to re-enroll after waiving coverage under the Plan. See *Section 6.4 Re-enrolling After Waiving Coverage*.

7.1 Special Enrollment Provisions

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

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

In order to enroll in the Program because of a special enrollment event described above, you must provide proof of the event in accordance with *Section 7.6 Documentation of Eligibility Required to Make Election Change* and enroll by the deadline described in *Section 7.7 Deadline to Enroll for Mid-Year Changes*. Your enrollment will be effective as of the date described in *Section 7.7 Deadline to Enroll for Mid-Year Changes*.

7.2 Change in Status

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

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

7.3 Consistency Rule

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

- 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's or Dependent Child's employer.
- The election change to the Program must ***correspond with*** that gain or loss of coverage.

7.4 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 election may allow you to change your UCC election. If your Spouse of Record/Domestic Partner of Record's employer's enrollment period is different from the Company'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 might no longer qualify for Plan coverage under the Program once you are eligible for Medicare. See *Section 4.4 Special Eligibility Rules if You or Your Dependents are Eligible for Medicare*.

7.5 Examples Applying the Mid-Year Election Change Rules

The table below shows some of the more common special enrollment or change in status events and the associated change you are permitted to make. Any change is subject to meeting the Dependent eligibility rules and the eligibility rules for the relevant coverage option, as applicable. See also *Section 6.4 Re-enrolling After Waiving Coverage*.

Event	Permissible Change
Gain a Dependent Child • Birth • Adoption • Marriage • Domestic Partnership	You may enroll, you may increase your level of participation (*e.g.*, Individual Only to Individual plus Dependent Child(ren)), or you may change to a different coverage option (*e.g.*, from an HMO to MAP Plus Option 1 or MAP Plus Option 2).

Event	Permissible Change
Lose a Dependent • Divorce • Death • Dependent loses eligibility • Termination of Domestic Partnership	You may decrease your level of participation (*e.g.*, Individual plus Spouse of Record to Individual Only). You may not change to a different coverage option (*e.g.*, from an HMO to MAP Plus Option 1 or MAP Plus Option 2).
Spouse of Record/Domestic Partner of Record loses medical coverage elsewhere	You may enroll, increase your level of participation (*e.g.*, Individual Only to Individual plus Spouse of Record), or change to a different coverage option (*e.g.*, from an HMO to MAP Plus Option 1 or MAP Plus Option 2).*
Move out of Plan service area	You may change to a different coverage option if you were enrolled in a Plan and move out of the Plan's service level. You may not change your level of participation (*e.g.*, Individual Only to Individual plus Spouse of Record).
Move into a Plan service area	You may enroll in or change to a Plan for which you become eligible as a result of moving. You may not otherwise switch your coverage option (*e.g.*, from one HMO to another) or change your level of participation (*e.g.*, Individual Only to Individual plus Spouse).

7.6 Documentation of Eligibility Required to Make Election Change

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

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

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 you and/or 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 or special enrollment 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 11. 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 4.3 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.

7.7 Deadline to Enroll for Mid-Year Changes

For any change made at any time outside of annual enrollment (typically in the fall of each year), you must submit the required proof of eligibility and request enrollment within 90 days of the change in status or special enrollment 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 or special enrollment event, the effective date of the mid-year election change will be the date of the change in status or special enrollment event.
  - If the Plan Administrator receives your enrollment request on day 32 through 90 after the change in status or special enrollment event, the effective date of the mid-year election change will be the Plan Administrator's processing date.
- 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 or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date of the event.
  - If the Plan Administrator receives your enrollment request within 90 days after the change in status or special enrollment event, the effective date of the mid-year election change will be the first of the month following the date the Plan Administrator receives your enrollment request.

Section 8. Premiums and Premium Cap

You and UCC 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. The amount you pay is the difference between the total cost of the Plan coverage and the Company's contribution to the premium costs.

8.1 Retiree Medical Budget (Maximum UCC Subsidy or the "Premium Cap")

UCC has established a Retiree Medical Budget. The Retiree Medical Budget is the maximum amount that UCC pays toward medical premiums for Retirees and Surviving Spouses of Record/Domestic Partners of Record. This maximum UCC subsidy is sometimes called the "Premium Cap" or "Retiree Medical Budget." *This budget affects premiums only, not benefit amounts paid for medical services. UCC may contribute less than the maximum set under the Retiree Medical Budget, in its sole discretion.*

The Retiree Medical Budget applicable to you depends on whether or not you are Medicare-eligible and whether or not you have "Full Service." (If you are not Medicare-eligible, you are considered "pre-Medicare-eligible.")

You are considered "Full Service" if--

- You are a Retiree who:
  - Retired on or after January 1, 2004 with at least 30 years of Service at your termination of employment with UCC;
  - Was hired before February 6, 2001 and had 85 or more Points at Retirement;
  - Retired on or after February 1, 1995 and before January 1, 2004, with 10 or more years of Service after age 45, or 85 or more points at time of Retirement; or
  - Retired before February 1, 1995, and you were at least 50 years old with 10 or more years of Service at time of Retirement; or
- You are a 60 Point Retiree Medical Severance Plan Participant who:
  - Has 30 or more years of Service at the time your employment with UCC ends;
  - Was hired before February 6, 2001 and has 85 or more Points; or
  - Terminated employment on or after August 1, 2003 and before January 1, 2004 and has either 10 or more years of Service after age 45 or 85 or more Points at termination of employment.

(Service is defined in the Plan Document and summarized in *Section 29. Definitions of Terms*.) Special rules for whether you are considered Full Service might apply if you are approved to receive a benefit under and considered "totally disabled," as defined in, The Dow Chemical Company Long Term Disability Program or the Union Carbide Employees' Pension Plan. See *Section 8.3 Long Term Disability Participants and Disability Retirees Under Union Carbide Employees' Pension Plan*, below.

For Pre-Medicare-Eligible Retirees Who Have Full Service

The UCC Retiree Medical Budget for pre-Medicare-eligible Retirees is set such that the maximum amount that UCC pays towards a Full Service pre-Medicare-eligible Retiree's premium is the same as the maximum amount that The Dow Chemical Company pays towards a Full Service Dow Pre-Medicare Retiree's premium under The Dow Chemical Company Retiree Medical Care Program. If you are a Full Service Participant and you are not Eligible for Medicare, UCC pays up to the maximum allowed under the premium cap.

The Retiree Medical Budget may be adjusted at the Company's sole discretion. Full Service Retirees should be prepared to pay the full amount of the cost of the Program above the premium cap. *The Retiree Medical Budget has been exceeded. Your retiree medical premium may increase significantly each year.*

For Medicare-Eligible Retirees Who Have Full Service

The maximum UCC subsidy (premium cap) was set at twice Union Carbide's share of the monthly MSP Basic Plan A rate in January 2000. This means that the maximum amount the Company contributes for each Full Service Medicare-eligible Retiree in a Union Carbide-sponsored health plan is $132.02 per month. Because this limit has been reached, you are responsible for the full amount of all premium cost increases. *Your retiree medical premiums may increase significantly each year.*

For Participants Who Do Not Have Full Service

If you do not have Full Service, then UCC pays a *portion* of the amount that UCC pays for Full Service Retirees. The portion UCC pays is determined as follows:

- If you Retired on or after January 1, 2004, the portion UCC pays is based on the Retiree Medical Support Schedule, below, subject to the premium cap. (The Retiree Medical Support Schedule applies regardless of whether your employment ended because of lay-off, disability or death.)
- If you Retired before January 1, 2004, the portion UCC pays is based on whichever Attribution Schedule (below) applies to you, subject to the premium cap. One Attribution Schedule applies if you are not Medicare-eligible and the other applies if you are Medicare eligible.

Your retiree medical premiums may increase significantly each year.

8.2 Retiree Medical Support Schedule

UCC Retiree Medical Support Schedule

This schedule determines the percent of the Full Service subsidy paid by you and the percent paid by UCC, and is applicable *if you Retire on or after January 1, 2004*.

Years of Service when employment with UCC ends[4]	Your Contribution Toward the Full Service Subsidy	UCC's Contribution Toward the Full Service Subsidy
10	60%	40%
11	57%	43%
12	54%	46%
13	51%	49%
14	48%	52%
15	45%	55%
16	42%	58%
17	39%	61%
18	36%	64%
19	33%	67%
20	30%	70%
21	27%	73%
22	24%	76%

[4] "Service" is defined in the Plan Document and summarized in *Section 29. Definitions of Terms*.

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Years of Service when employment with UCC ends[4]	Your Contribution Toward the Full Service Subsidy	UCC's Contribution Toward the Full Service Subsidy
23	21%	79%
24	18%	82%
25	15%	85%
26	13%	87%
27	11%	89%
28	9%	91%
29	7%	93%
30 or more	0%	100%

* Special provisions may apply to certain Retirees who have Service with a company or business that was acquired or sold by The Dow Chemical Company or UCC or who have service with a subsidiary or a company with whom UCC has entered into a joint venture or other business structure. Retirees with past service with such companies should contact the Retiree Service Center or refer to the Plan Document, which may be requested from the Plan Administrator.

Attribution Schedule[5]

For Pre-Medicare-Eligible Retirees

The following Attribution Schedule applies if you are not Medicare-eligible and you Retired before January 1, 2004 with less than 85 Points or fewer than 10 years of service after age 45.

Years of Service after age 45	**1-5**	**6**	**7**	**8**	**9**	**10**
% of Full Service Subsidy Paid by UCC						

For Medicare-Eligible Retirees

The following Attribution Schedule applies if you are Medicare-eligible and you Retired before January 1, 2004 with less than 85 Points or fewer than 10 years of service after age 45.

Years of Service after age 45	**1-5**	**6**	**7**	**8**	**9**	**10**
% of Full Service Subsidy Paid by UCC						

60 Point Retiree Medical Severance Plan Participants

If you are a 60 Point Retiree Medical Severance Plan Participant, you are subject to the premium caps described above and the following rules:

- If you terminated employment before January 1, 2004:

[5] The Attribution Schedule does not apply to Employees who Retired prior to January 1, 2004 due to lay-off, disability or death. Such Retirees are deemed to have Full Service.

- If you have Full Service, your premium is calculated the same way as the premium for a Retiree with Full Service. See *8.1 Retiree Medical Budget (Maximum UCC Subsidy or the "Premium Cap")*8.1 Retiree Medical Budget (Maximum UCC Subsidy or the "Premium Cap"), above.
- If you do not have Full Service, your premium is calculated according to the applicable Attribution Schedule or the Retiree Medical Support Schedule, whichever provides you the greater UCC subsidy.

- If you terminated employment on or after January 1, 2004, your premium is determined according to the Retiree Medical Support Schedule.

Special Rule for Retirees Whose Employment was Involuntarily Terminated between August 1, 2003 and January 1, 2004

You are eligible for special rule calculating your premium as if you have Full Service if you meet all of the following requirements:

- You are a Retiree whose employment with a Participating Employer was involuntarily terminated after August 1, 2003 and before January 1, 2004;
- You received a payment from the UCC U.S. Severance Plan;
- You are not a 60 Point Retiree Medical Severance Plan Participant; and
- You do not have Full Service.

You will be subject to the premium cap.

8.3 Long Term Disability Participants and Disability Retirees Under Union Carbide Employees' Pension Plan

If you are an Employee approved to receive a benefit under, and considered "totally disabled" as defined in The Dow Chemical Company Long Term Disability Program or the Union Carbide Employees' Pension Plan, your premium is determined as follows:

- If the effective date of your disability retirement under the UCEPP component of the Union Carbide Employees' Pension Plan is on or after February 7, 2003, and before January 1, 2006, UCC pays the full premium.
- Effective January 1, 2006, if the effective date of your disability retirement status under the UCEPP component of the Union Carbide Employees' Pension Plan is on or after January 1, 2006, UCC provides you a premium subsidy at the Full Service level, regardless of your actual years of service. You are required to pay a premium based on the Retiree Medical Support Schedule and the Retiree Medical Budget.

Your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level you had when you were an active Employee.

8.4 Premium Payments/ Excess Premium Payments

If your monthly premium amount is less than your monthly Union Carbide 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 UCC 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 UCC 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.

8.5 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 or UCC provides the primary coverage instead of Medicare, you will be required to pay the premiums applicable to pre-Medicare-eligible Retirees.

Section 9. Survivor Benefits

9.1 Surviving Spouse/Domestic Partner of a Deceased Employee

General Rule

In general, a Surviving Spouse/Domestic Partner of an active Employee is eligible for 36 months of COBRA coverage under the active employee medical plan, such as The Dow Chemical Company Medical Care Program, if he or she was covered under the active employee plan at the time of death. Refer to the summary plan description for the applicable active employee plan in which the Employee participated.

Exception for Active Employees Hired Before January 1, 2008

If the deceased Employee was hired before January 1, 2008 and was a vested participant of the Union Carbide Employee's Pension Plan with a benefit under the UCEPP component, an exception to the general rule above provides that a Surviving Spouse/Domestic Partner might be eligible for coverage under the Program. In such a case, the Surviving Spouse/Domestic Partner is eligible for coverage as a "Retiree" under the Program, in accordance with the following rules:

- If the deceased Employee would have been eligible for pre-Medicare retiree medical benefits had he or she continued to be employed at a Dow Entity and then Retired, then the Survivor is eligible for pre-Medicare benefits.
- If the deceased Employee would have been eligible for post-Medicare retiree medical benefits, then the Surviving Spouse/Domestic Partner is eligible for post-Medicare benefits.

- If the deceased Employee would not have been eligible for post-Medicare retiree medical benefits, then the Surviving Spouse/Domestic Partner is not eligible for post-Medicare benefits. In this case, once the Survivor is Eligible for Medicare, he is no longer eligible for coverage under the Program.
- If the Surviving Spouse/Domestic Partner is less than age 50 at the time of the active Employee's death, he or she will be offered benefits under the Program at active employee rates until he or she reaches age 50. At age 50, the Surviving Spouse/Domestic Partner is required to pay retiree rates as if he or she were a Retiree with Full Service. If the deceased Employee would not have been eligible for post-Medicare retiree medical benefits, then such rates will continue only until the earlier of--
    - the date that the deceased Employee would have reached age 65, or
    - the date the Survivor reaches age 65 (or otherwise becomes Eligible for Medicare).

  If the Survivor is no longer eligible for Retiree rates as a result of the rule described in the previous sentence, and the Survivor is not yet Eligible for Medicare, the Survivor may continue coverage under the Program until he or she becomes Eligible for Medicare but only if he or she pays 102% of the full cost of coverage from the date the deceased would have reached Medicare eligibility until the date the Survivor reaches Medicare eligibility.
- If the Surviving Spouse/Domestic Partner remarries, he or she cannot cover a new spouse or domestic partner.
- A Surviving Spouse/Domestic Partner does not need to be enrolled at the time of death to be eligible. However, depending on whether he is covered under another health plan, he may be restricted in which UCC plan he may enroll. The rules described above in *Section 6.4 Re-enrolling After Waiving Coverage* apply.
- A Surviving Spouse/Surviving Domestic Partner who works full-time (or is retired) and is eligible for employer-sponsored health coverage must be enrolled in that coverage in order to continue UCC or Dow coverage. If a Surviving Spouse/Surviving Domestic Partner is enrolled for UCC or Dow coverage, any surviving Dependent Children also may be covered as long as they meet eligibility requirements. In order to be eligible for coverage, the surviving Dependent Children must be enrolled in employer-sponsored coverage for which they are eligible. Such Dependent Children will be subject to the corresponding premium rate that is applicable to the Surviving Spouse/Domestic Partner.

If you were hired before January 1, 2008, and were a vested participant of the Dow Employees' Pension Plan with a benefit under the DEPP component, refer to the applicable Dow retiree medical summary plan description for a similar rule.

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

9.2 Surviving Spouse of Record/Domestic Partner of Record of a Deceased Retiree or Deceased 60 Point Retiree Medical Severance Plan Participant

If Hire Date is Before January 1, 2008

If a deceased Retiree (or 60 Point Retiree Medical Severance Plan Participant) was hired before January 1, 2008, and was a vested participant of the Union Carbide Employees' Pension Plan with a benefit under the UCEPP Component, his or her Surviving Spouse of Record/Domestic Partner of Record may continue UCC retiree medical coverage, regardless of whether he or she was enrolled in coverage in the Program at the time of the Retiree's death, subject to the following rules:

- If the deceased Retiree's hire date was before February 6, 2001, the Surviving Spouse of Record/Domestic Partner of Record is eligible for UCC medical coverage following the Retiree's death.
- If the deceased Retiree's hire date was on or after February 6, 2001, and the Surviving Spouse of Record/Domestic Partner of Record is Eligible for Medicare at the time of the Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record is ***ineligible*** for coverage under any UCC or Dow retiree medical program.
- If the deceased Retiree's hire date was on or after February 6, 2001, and the Surviving Spouse of Record/Domestic Partner of Record is ***not*** Eligible for Medicare at the time of the Retiree's death, then the Surviving Spouse of Record/Domestic Partner of Record is eligible for pre-Medicare coverage under the Program and for such coverage must pay:
  - the applicable Retiree premium (as determined subject to the Retiree Medical Support Schedule and Retiree Medical Budget) the Retiree would have paid, until the date the Retiree would have become Medicare-eligible.
  - 102% of the full cost to insure from the date the deceased Retiree would have become Medicare-eligible until the date the Surviving Spouse of Record/Domestic Partner of Record becomes Medicare eligible.

  The Surviving Spouse of Record/Domestic Partner of Record is ***not*** eligible for coverage after he or she becomes Eligible for Medicare.
- Depending on whether he or she is covered under another health plan at the time of the Retiree's death, the Surviving Spouse of Record/Domestic Partner of Record may be restricted in which UCC plan he or she may enroll.
- If a Surviving Spouse of Record/Domestic Partner of Record works full time or is retired, and is eligible for employer-sponsored health coverage (including from a former employer), the Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that coverage in order to obtain coverage under the Program.

If Hire Date is On or After January 1, 2008

If the deceased Retiree was hired on or after January 1, 2008, the Survivor is eligible only for COBRA coverage for 36 months at 102% of the full cost to insure. See *Section 12.2 COBRA Continuation Coverage*.

9.3 Surviving Spouse of Record/Domestic Partner of Record of a Deceased LTD Participant

If the deceased individual is a Participant in the Program as a result of being eligible to participate in the Union Carbide Employees' Pension Plan and approved to receive benefit payments from The Dow

Chemical Company Long Term Disability Program ("LTD"), Survivor benefits are determined as follows:

- If the deceased LTD Participant was hired on or after January 1, 2008 or had less than ten years of service and dies while still eligible for the 12- or 24-month period of medical coverage during which the LTD Participant pays active Employee premiums, the Surviving Spouse of Record/Domestic Partner of Record may continue coverage at the active Employee premium for the remainder of the 12- or 24-month period, whichever is applicable. After the expiration of the remainder of the 12- or 24-month period, the Surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules.
- If the deceased LTD Participant was hired before January 1, 2008 and had ten (10) or more years of Service at the time LTD payments commenced, and dies while still eligible for medical coverage, the Surviving Spouse of Record/Domestic Partner of Record is eligible for coverage under the same rules that apply to active employee deaths.

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

Remarriage (or entering a new domestic partnership) does not disqualify a Surviving Spouse of Record/Domestic Partner of Record 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 (or 60 Point Retiree Medical Severance Plan Participant's or LTD Participant'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 *6.4 Re-enrolling After Waiving Coverage*.

9.5 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 (or other Participant eligible for coverage under Section 4.2 of this SPD), 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 any 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 the 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 (or 60 Point Retiree Medical Severance Plan Participant or LTD Participant). Thereafter, if they were covered for the first 12 months and paid the required premiums, they will be offered the remaining 24 months of coverage at COBRA rates – 102% of the full cost to insure. *In order to be covered, the surviving Dependent Children must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.*

Section 10. 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 materials provided by your HMO, 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, the Company 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 the Company. In addition, if you would like another certificate of coverage, you can request one at any time within the 24-month period after your UCC 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 UCC of any change in your Dependent's eligibility status as soon as possible, and no later than during the annual enrollment period. The Company will provide a certificate of coverage for your covered Dependents upon request. If the Company 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

The Company and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates, including, but not limited to, the Plans under contract with UCC and the Plan Administrator. The Company may use

aggregate data and summary health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with Dow, UCC and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA. Effective April 14, 2003, each HMO is required by law to have a Notice of Privacy Practices which must be made available to HMO participants.

Section 11. 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, Dow or UCC 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, UCC, or any of their subsidiaries or affiliates 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 12. Ending Coverage

12.1 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 Plan for claims paid by the Plan that under the terms of the Plan, you or your Dependent are required to reimburse the Plan
- Failure to comply with the terms and conditions of the Program or the Plans
- Providing false or misleading information to the Program or the Plans

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 *12.2 COBRA Continuation Coverage*); or

- is eligible to participate after your death in accordance with *Section 9. Survivor Benefits*.

12.2 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 enrolls in Medicare (Part A, Part B, or both); or

(3) You become divorced or legally separated from your Spouse.

As explained under *Section 12.2 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 13. Subrogation

The provisions of this Section 13 shall not be construed to limit or restrict in any way the subrogation or reimbursement provisions set forth in materials provided by your Plan. Any such provisions in materials provided by your insurer or HMO shall apply in addition to the provisions of this Section 13. In case of conflict between this Section 13 and materials provided by your insurer or HMO, the Plan Administrator shall have exclusive authority to determine which documents will govern.

As used in this Section 13, 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.

13.1 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.

13.2 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 13 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.

13.3 Jurisdiction

For purposes of this Section 13, 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 14. Your Legal Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Program, including insurance contracts and collective bargaining agreements (if applicable), and 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 insurance contracts and 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 Group Health Plan Coverage. 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* 12.2 COBRA Continuation Coverage.

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

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

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

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

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

Section 15. Plan Administrator's Discretion

The Plan Administrators are the 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 Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For

a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Section 26. Claims Procedures*.

Section 16. Plan Document

The 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 17. 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 18. UCC's Right to Terminate or Amend the Program

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

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

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

Section 19. Litigation and Class Action Lawsuits

19.1 Litigation

If you wish to file a lawsuit against the Program or the Plan (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures described in the *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 for Plan Benefits), the date the Program first denied your request to exercise such right; or
3. in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

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

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

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

19.2 Class Action Lawsuits

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

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

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

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

Section 20. Incompetent and Deceased Participants

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

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

Section 21. Privilege

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

- the Advisor's client is the Advisee and not any 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 22. Waivers

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

Section 23. Providing Notice to Administrator

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

Section 24. Funding

The 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 described in *Section 8. Premiums and Premium Cap*. Benefits are underwritten by the HMO or insurer of the applicable Plan. The Program is an insured plan under ERISA.

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

Section 25. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program or Plan were provided to, or on behalf of, a Participant, 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 the materials provided by the HMO or insurer of your Plan describing the benefits it provides 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 to file 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 the HMO or insurer of your Plan.
- *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 as 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 19.1 Litigation* for the deadline for filing a lawsuit.

26.3 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim 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 materials provided by your HMO or insurer, 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 an eligibility determination,
- The name of the plan for which the eligibility determination is being requested (Union Carbide Corporation Insured Health Program), and
- 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 Union Carbide Corporation Insured Health 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 (Union Carbide Corporation Insured Health Program),
- Reference to the initial determination, and
- An explanation of the reason why you are appealing the initial determination.

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

Associate Director of North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674
Attention: Appeals Administrator for the Union Carbide Corporation Insured Health Program
(Claim for Eligibility Determination)

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

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

decision on the Claim, it will describe any additional material or information necessary to submit to the Program, and provide you with the deadline for submitting such information.

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

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

Section 27. Tax Consequences of Coverage and Benefits

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

Section 28. No Assignment of Benefits

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

Section 29. Definitions of Terms

The following are some of the defined terms of the Program. Additional terms are defined in the Plan Document for the Program and the materials provided by your HMO or insurer describing the benefits it provides. A copy of the Plan Document is available upon request of the Plan Administrator.

60 Point Retiree Medical Severance Plan Participant or 60 Point Severance Plan Participant
A "60 Point Retiree Medical Severance Plan Participant" as defined in the Plan Document.

Appeals Administrator:
The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is the applicable insurer or HMO for the Plan.. 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.

Attribution Schedule:
The attribution schedule described in this SPD. See *Section 8.2 Retiree Medical Support Schedule*.

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" or "Corporation":
Union Carbide Corporation.

Credited Service:
Credited service recognized under the Union Carbide Employees' Pension Plan.

Dependent:
A Retiree's, LTD Participant's, or 60 Point Retiree Medical Severance Plan Participant's Spouse of Record, Domestic Partner of Record, or Dependent Child(ren), or a child to whom a Qualified Medical Child Support Order applies.

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

- Your birth or legally adopted child; or
- Your Spouse of Record/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 4.3 of this SPD.

You may cover a child of your Spouse/Domestic Partner who is not your Spouse of Record/Domestic Partner of Record only if the child (1) is also your birth or adopted child (or a child for whom you are the

legal guardian) (as explained above) or (2) was covered as your Dependent under UCC retiree medical coverage prior to March 1, 2013, and remains continuously covered under UCC retiree medical coverage.

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

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

   1. the two people have lived together for at least twelve (12) consecutive months immediately prior to receiving coverage under the Program,
   2. the two people are not Married to other persons and were not Married to other persons at any time during the twelve (12) consecutive month period preceding coverage under the Program,
   3. the two people are and were, during the twelve (12) consecutive month period preceding coverage under the Program, each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely,
   4. both people are legally competent and able to enter into a contract,
   5. the two people are not related to each other in a way which would prohibit legal Marriage,
   6. in entering the relationship with each other, neither of the two people is acting fraudulently or under duress,
   7. during the twelve (12) month period preceding coverage under the Program, the two people have been and are financially interdependent with each other, and
   8. both people signed a statement acceptable to the Plan Administrator indicating the above requirements have been met and provided it to the Plan Administrator.

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

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

Domestic Partner of Record:
With regard to a Retiree (or 60 Point Retiree Medical Severance Plan Participant or LTD Participant)--

- who was eligible for coverage under the Program before January 1, 2003: a person who was eligible for Domestic Partner benefits from the Union Carbide Retiree Medical Care Program on December 31, 2002, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to December 31, 2002.); or
- who became eligible for coverage under the Program on or after January 1, 2003: a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. (In order for such a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.)

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

Dow:
The Dow Chemical Company.

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

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

Eligibility Service:
Eligibility service recognized under the Union Carbide 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 a Participating Employer directly from The Dow Chemical Company's U.S. payroll or a Participating Employer's U.S. payroll;
- 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:
A Retiree who:

- Retired on or after January 1, 2004 with at least 30 years of Service at your termination of employment with the Company;
- Retired on or after January 1, 2004, was hired before February 6, 2001 and had 85 or more Points at Retirement;
- Retired on or after February 1, 1995 and before January 1, 2004, with 10 or more years of Service after age 45, or 85 or more points at time of Retirement;
- Retired before February 1, 1995, and was at least 50 years old with 10 or more years of Service at time of Retirement; or
- Involuntarily terminated employment with a Participating Employer after August 1, 2003, and before January 1, 2004, received a payment from the UCC U.S. Severance Plan, and did not otherwise have Full Service.

Or a 60 Point Retiree Medical Severance Plan Participant who:

- Has 30 or more years of Service at the time his or her employment with the Company terminates;
- Was hired prior to February 6, 2001, and has 85 or more Points; or
- Terminated employment on or after August 1, 2003 and before January 1, 2004 and has either 10 or more years of Service after age 45 or 85 or more Points at termination of employment with the Company.

HIPAA:
The Health Insurance Portability and Accountability Act.

HMO:
Health Maintenance Organization.

Initial Claims Reviewer:
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the applicable HMO or insurer for the Plan. 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 a Malaysian national is "Localized" to the U.S. when a Participating Employer has determined that such Employee is permanently relocated to the U.S., and such Employee has accepted such determination.

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

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

Married or Marriage:
A civil contract between two individuals who have the legal capacity to marry and that is formalized by a marriage license. Whether a person is "Married" for purposes of the Program shall be determined in

accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue Service and the Department of Labor. For periods before September 16, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Program then in effect. The Program does not recognize common law marriage except that:

1. if an Employee or Retiree was a participant in a medical plan sponsored by the Company any time between February 5, 2001 and December 31, 2001, 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 medical plan sponsored by UCC any time between February 5, 2001 and December 31, 2001, then such common law spouse is deemed under the Program to be Married to the Retiree; and
2. the Plan recognizes a marriage that meets the requirements of Texas Family Code Annotated § 2.402.

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

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

"Medicare-eligible" or "Eligible for Medicare":
A person who is eligible for Medicare because he 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.

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

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

Participant:
A Retiree, 60 Point Retiree Medical Severance Plan Participant, LTD Participant, Dependent, Survivor, or other individual who participates in 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 "Union Carbide" have the same meaning and are used interchangeably. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan:
The HMO or insured product that provides coverage from the HMO or insurance carrier. There are many "Plans" offered through HMOs and insurance carriers under 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 Union Carbide Corporation in accordance with the Plan Document.

Plan Document:
The plan document for the Program, which is ERISA Plan #555. The summary plan descriptions for the plans offered under the Program are integral parts of the Plan Document.

Points:
The sum of a person's age and Service. For example, if a person is 55 years old with 30 years of Service, he has 85 Points.

Program:
The Union Carbide Corporation Insured Health Program.

QMCSO:
A QMCSO is a "Qualified Medical Child Support Order". This is a court order that gives a child the right to be covered under the Program. If a QMCSO applies, the child is eligible for coverage as your Dependent. You can obtain a free copy of the Program's QMCSO procedures, which explain how the Program determines whether a court order meets the 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 the date when an Employee becomes a Retiree.

Retiree:
Retiree means a "Retiree" within the meaning of the Plan Document, which generally is:

- For individuals who terminate employment after February 6, 2001, a Retiree means a former Employee who:
  - was age 50 or older with at least 10 years of Service at the time his employment terminated with a Dow Entity, who is also a "retiree" under the terms of the Union Carbide Employees' Pension Plan with a vested benefit under the UCEPP Component; or
  - has been Localized in the U.S. and:
    - is still a Localized U.S. Employee when his employment with a Dow Entity ends;
    - is age 50 or older with 10 or more years of Service when his employment with a Dow Entity ends;
    - at the time he was Localized in the U.S., he was eligible for the UCEPP Component of the Union Carbide Employees' Pension Plan,[6] although he need not participate in Union Carbide Employees' Pension Plan or be vested in the Union Carbide Employees' Pension Plan at the time his employment ends; and

[6] However, a Company-sponsored Localized Employee whose hire date at a Dow subsidiary was prior to January 1, 2008 and who was Localized in the U.S. between January 1, 2008 and September 1, 2009 who is a vested participant in the PPA component of the Union Carbide Employees' Pension Plan will meet this requirement. Such Employees are also "Retirees."

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

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

- Until and through February 5, 2003, for individuals who were employed by the Company before February 6, 2001, and became "retirees" under the Union Carbide Employees' Pension Plan (as "retiree" is defined under that retirement program) on or after February 6, 2001, a Retiree also includes a former Employee who was age 47 or older with at least 7 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under the Union Carbide Corporation Special Severance Protection Program.
- Until and through February 5, 2001, for individuals who were employed by the Company before February 6, 2001, and became "retirees" under the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries (as "retiree" is defined under that retirement program) before February 6, 2001 (and were not employed by a successor employer or a divested or joint venture business), a Retiree includes a former Employee who was involuntarily terminated by action of a Participating Employer and:
  - was age 48 or older with at least 8 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and commenced a benefit under the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries at the time of termination of employment; or
  - was age 47 or older with at least 7 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under a severance program sponsored by the Company.
- For individuals who retired under the Union Carbide Employees' Pension Plan (formerly known as the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries, and also referred to as "UCEPP") before the acquisition of Union Carbide Corporation by The Dow Chemical Company (February 6, 2001), a Retiree is an employee who has terminated from Union Carbide (and is not employed by a successor employer or a divested or joint venture business) and was eligible at the time of his or her termination, due to meeting age and service requirements of the Union Carbide Employees' Pension Plan, to immediately commence his or her pension benefit and continue participation in the Company's medical plans.

Retiree Medical Budget:
The maximum amount of aggregate premium that the Company may pay in any single year.

Retiree Medical Participant:
This term is used in the context of explaining the Retiree Medical Budget in Section 8. Premiums and Premium Cap. It means a Retiree, a 60 Point Retiree Medical Severance Plan Participant, or an LTD Participant, or a Survivor who is a participant in a Plan (other than the International Medical and Dental Plan) offered under the Program or the Union Carbide Retiree Medical Care Program.

Service:
Except for Retirees who have been Localized in the U.S., and except as otherwise specifically provided in the Plan Document:

- For a former Employee who was hired or re-hired on or after February 6, 2001 but before January 1, 2008 by a subsidiary or affiliate of the Company or The Dow Chemical Company that was 80% or more owned by the Company or The Dow Chemical Company at the time such Employee was hired by such subsidiary or affiliate, "Service" shall mean "credited service" recognized by the UCEPP component of the Union Carbide Employees' Pension Plan (if any).

For purposes of determining whether the hire date is on or after January 1, 2008, the following rules apply:

- For a former Employee of an entity acquired by the Company or The Dow Chemical Company on or after February 6, 2001, but before January 1, 2008, the Program deems the hire date to be the later of (1) the date the entity became a Participating Employer under the Program, or (2) the Employee's hire date at such entity.
- For a former Employee of an entity acquired by the Company or The Dow Chemical Company on or after February 6, 2001, but before January 1, 2008, which entity does not become a Participating Employer under the Program, who subsequently is hired by the Company, the hire date shall be the date the Company hired such Employee.

For purposes of determining your Service, the following rules apply for former Employees who are rehired:

- If the rehired former Employee is a participant in the UCEPP component of the Union Carbide Employees' Pension Plan on the date of rehire, the Program recognizes the first hire date to determine whether eligibility or credited service (as recognized by the Union Carbide Employees' Pension Plan) applies, and to determine how much Service is recognized by the Program.
- If the rehired former Employee is NOT a participant in the UCEPP component of the Union Carbide Employees' Pension Plan on the date of rehire, the Program recognizes the first hire date to determine whether eligibility or credited service (as recognized by the Union Carbide Employees' Pension Plan) applies, and to determine how much Service will be recognized by the Program; provided, however, that (1) on the date the individual terminated employment with Union Carbide, he or she was eligible for coverage under the Program as a Retiree or 60 Point Retiree Medical Severance Plan Participant, (2) the individual was subsequently rehired by Union Carbide, and (3) after rehire, the individual became a participant in the Personal Pension Account component of the Union Carbide Employees' Pension Plan.

For Retirees who have been Localized in the U.S.:

- Only for purposes of determining eligibility, "Service" means the period(s) of time that the Retiree worked for the Company or any affiliate or subsidiary owned 80% or more by the Company.
- For purposes of determining whether the hire date was on or after February 6, 2001, the Program recognizes hire dates and periods of employment with subsidiaries and affiliates that provide subsidized retiree medical coverage for their employees in an amount comparable to the Company's subsidization of the Program, and with subsidiaries and affiliates that are located in countries whose governments provide coverage comparable to the Program's coverage to such subsidiaries and affiliates' retirees.
- For purposes of the Retiree Support Schedule, "Service" includes the period(s) of time that the Retiree worked for a 50% or more owned subsidiary or affiliate of the Company only if, during

such period(s), such subsidiary or affiliate subsidized retiree medical coverage for its employees in an amount comparable to the Company's subsidization of the Program; or, such subsidiary or affiliate was located in a country whose government provides coverage comparable to the Program's coverage to such subsidiary or affiliate's retirees.

Special provisions regarding the definition of "Service" may apply in certain merger, acquisition, joint ventures and other special circumstances. For details, contact the Retiree Service Center or refer to the Plan Document.

Spouse
A person who is Married to an Employee, Retiree, LTD Participant, or 60 Point Retiree Medical Severance Plan Participant. See the definition of Marriage for further details. With regard to a Retiree (or other Participant eligible for coverage under Section 4.2 of this SPD), your Spouse must be your Spouse of Record in order to be eligible for coverage under the Program.

Spouse of Record:
With regard to a Retiree (or other Participant eligible for coverage under Section 4.2 of this SPD)--

- who was eligible for coverage under the Program before January 1, 2003: the person who was Married to the former Employee on December 31, 2002, and continues to be Married to the former Employee; or
- who became eligible for coverage under the Program on or after January 1, 2003: the person who was Married to the former Employee on his or her last day on the payroll, and continues to be Married to the former Employee.

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

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

Summary Plan Description ("SPD"):
The summary plan description for the Plans offered under the Program except the International Medical and Dental Plan. The summary plan description 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 or 60 Point Retiree Medical Severance Plan Participant or LTD Participant 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 (or other Participant); provided, however, that the deceased Retiree (or other Participant) was a vested participant of the Union Carbide 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:
Union Carbide Corporation.

UCC 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 Program.

"UCC Retiree Medical Care Program" or "Union Carbide Retiree Medical Care Program":
Union Carbide Corporation Retiree Medical Care Program, which is an ERISA benefit plan sponsored by Union Carbide Corporation as ERISA Plan #540.

UCEPP:
The UCEPP component of the Union Carbide Employees' Pension Plan.

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

Union Carbide Insured Health Program:
Union Carbide Corporation Insured Health Program, which is an ERISA benefit plan sponsored by Union Carbide Corporation as ERISA Plan #555.

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 Wrapper, please contact the Retiree Service Center using the contact information in *Section 1. ERISA Information*. For information about benefits covered under a specific Plan, or claims for Plan benefits, contact the specific Plan. If you need help in finding an address or phone number for your Plan, contact Secova.

IMPORTANT NOTE

This SPD Wrapper, together with the materials provided by the applicable Plan, is intended to constitute the Summary Plan Description ("SPD") for the Plan applicable to retirees and offered under the Union Carbide Corporation Insured Health Program (the "Program"). However, the SPD is not all-inclusive and it is not intended to take the place of the Program's legal documents.

The Union Carbide Corporation reserves the right to amend, modify or terminate the Program (and any underlying plan) at any time in its sole discretion.

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

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

Applicable to Plan Year 2014

The Union Carbide Corporation Insured Health Program does provide Creditable Coverage for prescription drugs for the following plans:

- Triple S Plan
- Aetna Medicare Advantage PPO
- All health maintenance organizations (HMOs) participating in the Rohm and Haas Insured Health Program that are available for those who are not eligible for Medicare ("UCC-approved HMOs")
- All health maintenance organizations (HMOs) participating in the Union Carbide Corporation Insured Health Program that are available for those who are not eligible for Medicare ("UCC-approved HMOs")

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 Union Carbide Corporation 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Union Carbide Corporation has determined that the prescription drug coverage offered by all of the UCC participating HMOs are 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 UCC coverage will be affected. If you enroll in Medicare prescription drug coverage (other than a Medicare Advantage-PD Plan offered through the Union Carbide Corporation Insured Health Program), you will be disqualified from participation in any

retiree medical and prescription coverage sponsored by the Union Carbide Corporation while you are enrolled in the Medicare prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current UCC coverage, be aware that you and your dependents will be able to get this coverage back during the annual enrollment period; provided that you are eligible for coverage under the Program and HMO post-Medicare eligibility.

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 UCC 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 will also get it before the next period you can join a Medicare drug plan, and if this coverage through UCC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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 B. 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</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</td></tr>
</table>

Medicaid Phone: 1-800-926-2588	Phone: 1-800-694-3084
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