Summary Plan Description “Wrapper” for:
Health Maintenance Organizations (HMOs) and
Insured Health Plans Participating in:

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

Applicable to eligible active employees

Amended and Restated February 27, 2012
Effective January 1, 2012 and thereafter until superseded

This Summary Plan Description (SPD) is updated annually on the Dow Intranet and supersedes all prior SPD’s.
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APPENDIX A Important Notice of Creditable Coverage for Medicare-Eligibles
# Section 1. ERISA Information

The Dow Chemical Company Insured Health Program  
SPD Wrapper for HMOs and Insured Plans applicable to Eligible Active Employees

| Plan Sponsor:       | The Dow Chemical Company  
|                     | Employee Development Center  
|                     | Midland, Michigan 48674 |
| Employer Identification Number: | 38-1285128 |
| Plan Number:       | 601 |
| Claims Administrator | With respect to claims and questions concerning benefits coverage:  
|                     | The applicable HMO or insured health plan  
|                     | With respect to eligibility to participate in the Program: N.A. Health and Welfare Leader  
|                     | The Dow Chemical Company  
|                     | Employee Development Center  
|                     | Midland, Michigan 48674  
|                     | (877) 623-8079 or (989) 638-8757 |
| Plan Administrator: | N.A. Health and Welfare Leader  
|                     | The Dow Chemical Company  
|                     | Employee Development Center  
|                     | Midland, Michigan 48674  
|                     | (877) 623-8079 or (989) 638-8757 |
| To Apply for or to Appeal Denial of a Claim: | See Claims Procedures in Section 23 |
| To Serve Legal Process File with: | The applicable HMO or insured health plan at the address provided by the HMO or insured health plan. |
| COBRA | Towers Watson  
|       | BenefitConnect COBRA Service Center  
|       | PO Box 919051  
|       | San Diego, CA 92191-9863  
<p>|       | (877) 292-6272 |
| HMO Network Manager | Secova, Inc. (formerly known as UltraLink) is the HMO Network Manager for HMOs offered to Employees and their Dependents. |</p>
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<td>Participating Employers share the premium costs with Employees. Employee contributions are made through payroll deduction. Benefits are underwritten by the applicable HMO or insured plan. The applicable HMO or insured plan is liable to pay the benefits, not the Participating Employer. Any assets of the Program can be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses can include, and are not limited to, consulting fees, actuarial fees, attorney fees, third-party administrator fees and other administrative expenses.</td>
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| **EAP**       | Aetna Employee Assistance Program  
151 Farmington Avenue  
Mailstop RS 32  
Hartford, CT 06156 |
Section 2. Summary Plan Description “Wrapper”

This is the Summary Plan Description ("SPD") “Wrapper” ("SPD Wrapper") for Health Maintenance Organizations (HMOs) and insured health plans (except The Dow Chemical Company International Medical and Dental Program) that are offered through The Dow Chemical Company Insured Health Program ("Program") as applicable to eligible active Employees. The HMOs and insured plans, except The Dow Chemical Company International Medical and Dental Program, offered by the Program are listed each Fall in the annual enrollment materials. This SPD Wrapper addresses:

- ERISA Information
- EAP
- Eligibility for Coverage
- Enrollment
- Premiums
- Your Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other legislation
- Information Exchanged by the Plan’s Service Providers
- Filing and Appealing Claims for an Eligibility Determination
- Fraud Against the Program
- Survivor Benefits
- Ending Coverage and your rights under COBRA
- Your Legal Rights under ERISA
- The Program provides Welfare Benefits
- Dow’s Right to Terminate or Amend the Program
- Disposition of Plan Assets if the Program is Terminated

This SPD Wrapper does NOT address the information listed below. Such information can be found in the materials provided to you by the applicable HMO or insured plan. The SPD Wrapper, when combined with the materials provided to you by the HMO or insured plan are intended to constitute the Summary Plan Description for the HMO plan or insured plan. The materials provided by the HMO or insured plan should address the following:

- Benefits covered under the applicable HMO or insured plan and the coverage levels
- Terms and Conditions for benefits coverage under the applicable HMO or insured plan
- Copays, deductibles, out of pocket maximums and coverage limitations
- Filing and appealing Claims for 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 HMO or insured plan
- HIPAA notice of privacy practices
Section 3 (A) About HMO’s

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, the 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 charge not paid by the HMO becomes your responsibility—not Dow’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.

In general, if you leave Dow employment, you can convert to an individual policy with your HMO. Also, under certain circumstances, you can 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 the section of this SPD Wrapper entitled Your Right to Continuation Coverage Under COBRA for details, or contact the Dow HR Service Center at (877) 623-8079 or (989) 638-8757 in Midland, Michigan, for details about COBRA. For details about converting your HMO coverage to an individual policy, contact your HMO or Secova.

### 3.2 Dow and HMOs

When you enroll in an HMO, you are not enrolled in a benefit plan designed or administered by Dow except for Dow’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 separate from Dow. By joining an HMO you agree to obtain your health care coverage through the HMO. Dow’s primary contact with the HMO is the payment of premiums, your portion through payroll deduction and Dow’s.

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 is your responsibility, not Dow’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.

### 3.3 Information that Your HMO Should Provide You

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

- the nature of services provided the HMO’s members;
- conditions pertaining to eligibility to receive such services, other than general conditions pertaining to eligibility required by Dow described in this SPD Wrapper;
- the circumstances under which services can be denied;
- the procedures to be followed in obtaining such services and the procedures available for the review of the Claims for Benefits that are denied in whole or in part.
Secova can assist you in obtaining these HMO materials if you need help getting them from the HMO.

### 3.4 Secova, the HMO Network Manager

Dow has hired Secova, Inc. (formerly known as UltraLink) to manage the HMOs that participate in The Dow Chemical Company Insured Health 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, Dow’s HMO Network Manager, at (800) 7DOWDOW. In addition, your open enrollment materials also will provide you with further details.

### 3.5 Grandfathered HMO’s

Dow believes that the HMO’s offered under the Program are “grandfathered health plans” under the Patient Protection and Affordable Care Act (PPACA). Contact the HMO directly if you want to know whether the HMO plan is grandfathered.

Being a grandfathered health plan means that this specific HMO’s plan does 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 Human Resources (HR) Service Center, Employee Development Center, Midland, Michigan 48674, telephone (877) 623-8079 or (989) 638-8757. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Section 3 (B). Employee Assistance Plan (“EAP”)**

All active Employees and their Dependents who are enrolled in any of the HMO’s are eligible for free EAP services. EAP provides professional and confidential counseling on emotional, social and mental health issues for employees and dependents experiencing personal difficulties. Participation is voluntary and typically self-referred. EAP support is available on a 24-hour per day, 7-day per week basis. EAP provides up to six visits to an EAP counselor for assessment and referral or short-term counseling. The types of problems supported by EAP include:

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

When the EAP services are not medical in nature, they are called “EAP Direct Services”. The part of EAP that provides EAP Direct Services is not part of any HMO Plan. Sometimes, during the EAP counseling sessions, a limited amount of mental health counseling occurs, which is medical in nature. The part of EAP that provides these limited mental health

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1 EAP Direct Services are not offered under Dow ERISA Plan #501 or Dow ERISA Plan #601, or any other Dow-sponsored ERISA plan.
services is an adjunct component of each of the HMO Plans because this portion of EAP provides services that are medical in nature. This part of EAP is called “Medical EAP”. Medical EAP is an adjunct component each HMO Plan. Regardless of the HMO carrier, EAP is administered by Aetna:

Aetna Employee Assistance Program
151 Farmington Avenue
Mailstop RS 32
Hartford, CT 06156

To contact a local EAP provider, go to:

While Medical EAP provides limited mental health benefits offered as an adjunct component of the HMO Plan at no cost to you, if you are enrolled in the HMO Plan, the HMO Plan also provides more extensive mental health coverage and that coverage and the costs of coverage are described in the materials provided by the HMO you are enrolled in, which are a part of this SPD.

Am I Still Eligible for EAP If I Am Not Enrolled In an HMO?

Yes. If you decided not to enroll in an HMO, but instead enrolled in one of the other medical plans offered by Dow to active employees, you are still eligible for free EAP benefits. Your Medical EAP benefits are provided by the active employee medical plan that you are enrolled in. Regardless of which active medical plan you are enrolled in, your EAP benefits are administered by Aetna at the Farmington Ave. address above.

Even if you did not enroll in any medical plan offered by Dow to active employees, you are still eligible for free EAP benefits. If you did not enroll in any Dow medical plan, your Medical EAP benefits are provided by the MAP Plus Plan. Your EAP benefits are administered by Aetna at the Farmington Ave. address above.

Section 4. Eligibility

4.1 HMO Availability

Besides meeting the eligibility criteria described in this SPD Wrapper, in order to participate in a particular HMO or insured plan, you must be located where the HMO or insured plan is available.

4.2 Employee Eligibility

Employee Eligibility:

Except as otherwise provided in this Section 4.2, an eligible Employee is defined as:

- an active, regular, Full-Time or Less-Than-Full-Time Salaried U.S. Employee of The Dow Chemical Company or entity that The Dow Chemical Company has authorized to participate in the Program (The Dow Chemical Company and the other authorized entity are each a “Participating Employer”), who is not covered by the Dow International Medical and Dental Program; or
- an active, regular, Full-Time Bargained-for U.S. Employee of a Participating Employer whose Bargaining Unit and the Participating Employer have agreed to the Program. However, if the terms
of the collective bargaining agreement specifically address which Employees are eligible or not eligible for this Plan, then the terms such collective bargaining agreement shall govern as to whether an Employee is eligible.

If you are a Rohm and Haas Company Employee who has been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan’s Short Term Disability Program\(^2\), you are eligible for medical coverage until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan’s Short Term Disability Program. You must pay the same premiums active Employees are required to pay.

If you are a Rohm and Haas Company Employee who has been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan’s Long Term Disability Program or you are a Morton International, Inc. Employee who was approved for disability payments under the Rohm and Haas Company Health and Welfare Plan’s Long Term Disability Program due to a qualifying disability incurred prior to October 1, 2009, you are eligible for medical coverage until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan’s Long Term Disability Program. Except as otherwise specified in a collective bargaining agreement, you must pay the same premiums active employees of Dow pay for comparable coverage.

If you do not meet the eligibility requirements above, you still may be eligible if you live in Hawaii, and the Participating Employer is required to provide you coverage under the Hawaii Pre-Paid Health Care Act of 1974.

A “regular” Employee is an Employee who is classified by the Employer as “regular.”

**Benefit Protected Leave of Absence:**

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

**International Medical and Dental Program:**

Expatriates and their eligible Dependents should refer to the Dow International Medical and Dental Plan Summary Plan Description to determine their eligibility and coverage under that plan. Those who are eligible for coverage under The Dow International Medical and Dental Plan are not eligible for coverage under HMOs or other insured plans offered under The Dow Chemical Company Insured Health Program.

### 4.3 Dependent Eligibility

Eligible Employees can enroll their eligible Dependents. A Dependent may be an Employee’s Spouse, an Employee’s Domestic Partner or an eligible child. An Employee must be enrolled in order to enroll a Dependent Spouse/Domestic Partner or Dependent child. If you enroll your Spouse/Domestic Partner or Dependent Child, you are required to provide their social security number to the Plan if requested to do so by the Plan.

**Dropping or Adding a Domestic Partner:**

You must file a Termination of Domestic Partnership form with the Plan Administrator by using the Dow Benefits web site or calling the HR Service Center, and wait at least twelve (12) months after filing the Termination of Domestic Partnership form before you can add a new Domestic Partner as your

\(^2\) If you are a Morton Salt Employee, this paragraph does not apply to you. You are not eligible for coverage under The Dow Chemical Company Insured Health Program.
dependent. In addition, you must file a new Statement of Domestic Partner Relationship for the new Domestic Partner.

Adding a New Domestic Partner after Termination of a Prior Domestic Partnership
You must file a Termination of Domestic Partnership form with the Plan Administrator by using the Dow Benefits web site or calling the HR Service Center, and wait at least twelve (12) months after filing the Termination of Domestic Partnership form before you can add a new Domestic Partner as your dependent. In addition, you must file a new Statement of Domestic Partnership for the new Domestic Partner.

Spouse and Domestic Partner Exclusions
Your Spouse or Domestic Partner is not eligible for coverage under the Program if he is:
- eligible for coverage as a full-time employee or retiree under another employer’s plan, but not enrolled for personal coverage in that plan (see the Working Spouse/Domestic Partner Rule section for details), or
- enrolled for coverage as an Employee or Retiree under another Dow or Dow-affiliated Plan, or
- serving in the armed forces of any country.

The Working Spouse/Domestic Partner Rule:
If your Spouse/Domestic Partner is working full time or retired and your Spouse/Domestic Partner’s employer offers subsidized group health coverage to its employees or retirees, you cannot cover your Spouse/Domestic Partner as a Dependent under the Program unless your Spouse/Domestic Partner has enrolled himself in his/her employer’s group health plan. If your Spouse/Domestic Partner’s employer does not subsidize the group health coverage, he/she is not required to enroll. However, if there is an employer subsidy, no matter how large or small the subsidy is, or what the premiums are, your Spouse/Domestic Partner must enroll to be eligible for coverage as a Dependent under the Program.

If the Plan learns that an Employee has a Spouse/Domestic Partner who has inadvertently failed to enroll in the medical plan available to them through their own employer as a result of their full-time employment, the Program will offer coverage at 102% of Dow’s cost. This coverage (at 102% of the full cost) will be retroactive to January 1 of the plan year in which the Plan learns that the Spouse/Domestic Partner failed to enroll in his/her employer’s group health plan. If the Spouse/Domestic Partner incurred Claims during the year prior to such plan year, the Employee has the option to purchase coverage for the entire prior year at 102% of the full cost to insure. Therefore, the Employee can choose coverage for the current plan year (in which the Spouse/Domestic Partner’s failure to enroll in his employer’s group health plan was discovered by the Program), or the current plan year plus one prior year. The Plan will not allow retroactive coverage for partial years.

The following is required in order to have such coverage on your Spouse/Domestic Partner:
- the Spouse/Domestic Partner was enrolled in the Program at the normal premium when the Plan learns that he/she was eligible for his/her employer’s group health plan.
- the Spouse/Domestic Partner will be required to enroll in coverage through his/her employer’s group health plan at the earliest possible date, which date you must provide to the Plan before being able to cover your Spouse/Domestic Partner at 102% of the cost of coverage.

If the two previous bulleted items are met, and you cover your Spouse/Domestic Partner, and then drop him/her from your Dow coverage, or fail to pay the 102% premium, you cannot re-enroll your Spouse/Domestic Partner until the next Dow open enrollment period that occurs after your Spouse/Domestic Partner has enrolled in his/her plan.

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3As used in the Spouse/Domestic Partner Exclusions paragraphs of this SPD, “employer” means someone who employs another. It also includes the partner or owner of a business. As used in these sections, “employees” (without a capital “e”) includes partners and owners, as well as those who are providing services in an employer-employee relationship. These definitions also apply to the paragraphs of this SPD entitled The Working Spouse/Domestic Partner Rule; Waiving Coverage – Working Spouse/Domestic Partner and Mid Year Election Changes.
If your Spouse’s/Domestic Partner’s employer offers more than one group health plan, your Spouse/Domestic Partner must enroll himself/herself in the “group health plan” that is most comparable to the Dow Plan in which you are enrolled. If your Spouse/Domestic Partner is enrolled for the Dow Plan, the Dow Plan will be coordinated according to the plan offered by your Spouse’s/Domestic Partner’s employer that is most comparable to the Dow Plan you are enrolled in, regardless of the plan in which your Spouse/Domestic Partner is actually enrolled.

If the 102% of premium option described above is either not applicable or not elected by the Employee/Retiree, then during the period of time when the Spouse of Record/Domestic Partner of Record did not satisfy the Working Spouse/Domestic Partner Rule, coverage under the Dow Plan is cancelled.

There is not a requirement that your Dependent children must enroll in your Spouse/Domestic Partner’s plan to be eligible under the Program. If you decide to enroll your eligible Dependent child(ren) under the Program, and your Spouse/Domestic Partner also enrolls them under his employer’s group health plan, the benefits for the child(ren) will be coordinated between the two health plans.

Please note that you may want to consider carefully whether it is advantageous to enroll your Spouse/Domestic Partner as a Dependent under the Dow Plan if the coverage offered by his or her employer is as comprehensive or better coverage than the Dow Plan. The Dow Plan would be secondary to your Spouse/Domestic Partner’s medical plan under the Dow Coordination of Benefits rules. You may choose to waive coverage for him/her under the Dow Plan in order to save premium dollars. If you waive Dow coverage, then no coordination of benefits will occur.

**Exception to the Working Spouse/Domestic Partner Rule:**

**Dual Dow Active Employee and Retiree Spouse/Domestic Partner**

If your Spouse/Domestic Partner is a Dow Retiree (or 60 Point or 65 Retiree Medical Severance Plan Participant or 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/Domestic Partner is not required to enroll in that coverage in order to have coverage under the Plan.

**Dependent Child(ren):**
A child is eligible 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’s or Domestic Partner’s natural or adopted child; or,
- a child for whom you or your Spouse/Domestic Partner have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the first 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, and
  - authority to enlist the child in the armed forces of the U.S.; and
  - 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 a “Dependent child”, the child must be less than age 26, except that a child who is age 26 or older and incapable of self-sustaining employment because of a physical or mental disability, and is covered under the Plan prior to the child’s 26th birthday, may continue coverage.

If you enroll your Domestic Partner's child(ren), you must have the Plan Administrator's "Statement of Domestic Partner Relationship" on file with the Plan, and your Domestic Partner must meet the Plan's definition of Domestic Partner. In addition, your Domestic Partner's child(ren) must meet all of the eligibility criteria outlined in this SPD.

**Qualified Medical Child Support Orders:**

A child who does not qualify as a “dependent child” above, may still be eligible for coverage if the Employee 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. It gives a child the right to be covered under one of the Dow Plans. Typically, a divorce decree that orders the Employee to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree also provides the following information. The Plan will also deem a divorce decree that orders the Employee to provide medical coverage for a specific child a QMCSO if the following information is also provided with the divorce decree in a document signed by either the Employee or the custodial parent (as long as such document contains information consistent with the divorce decree):

- Clearly specifies the name and last known mailing address of each child for whom the Employee must provide medical coverage, and
- Gives a reasonable description of the type of coverage to be provided to the child, and
- States the period for which the coverage is to be provided (within Dow’s rules).

In order to provide coverage to a child under a QMCSO, the Employee must be eligible for coverage under the Program. Note that if there is any ambiguity in, or between, the document(s) signed by the Employee or custodial parent, the Plan reserves the right to require the Employee and/or custodial parent to obtain a court order to clear the ambiguity.

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 (listed in the ERISA Information section of this SPD).

**Other Dependent Child Exclusions**

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

- **is covered as a Dependent under a Dow-sponsored or UCC-sponsored retiree medical plan** – all eligible child(ren) in a family must be covered by the same parent (exceptions can be made as necessary in stepchild situations).
- **reaches age 26** – coverage ends on the child’s 26th birthday. Children age 26 or older are not eligible. However, coverage can continue beyond age 26 if, prior to age 26, he/she is incapable of self-sustaining employment because of a physical or mental handicapping condition and is covered under the Plan on the day prior to reaching age 26. The child must be principally dependent upon you for support. Proof of the child’s initial and continuing dependency and incapacity must be provided to the Program prior to age 26 in order for coverage to continue. You must make any contribution required by the Program to continue coverage for your child. Once the coverage is terminated, it cannot be reinstated. Contact the Dow HR Service Center at (877) 623-8079 or in Midland at (989) 638-8757 for more information if this applies to you.
When your child is no longer eligible for Dependent coverage because of one of these 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. If you are an active Employee, complete a new enrollment on the Dow Benefits website or call the HR Service Center. If you fail to enroll within 90 days, according to government regulations for pre-tax deductions, you cannot make the change until the following annual enrollment period, with any reduction in premium effective at the beginning of the next calendar year. 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 entitled Your Right to Continuation Coverage Under COBRA.

4.4 Eligibility Determinations of Claims Administrator are Final and Binding

The Dow N.A. Health and Welfare Leader is the Claims Administrator that determines eligibility. The N.A. Health and Welfare Leader is a fiduciary of the Program and with respect to Eligibility Determinations, has the full discretion to interpret provisions of the SPD Wrapper and the Plan Document and to make findings of fact. Interpretations and eligibility determinations by the N.A. Health and Welfare Leader are final and binding on Participants. If you would like the N.A. Health and Welfare Leader to determine whether you are eligible for coverage, you can file a “Claim for an Eligibility Determination.” See Claims Procedures in Section 23.

Section 5. Enrollment

5.1 Levels of Participation

Levels of Participation

The levels of participation available are:

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

The Employee must be enrolled in order to enroll a Dependent Spouse/Domestic Partner or Dependent child. The Employee may only enroll the Dependent in the same plan that the Employee is enrolled in. A Dependent may not be enrolled in a Dow plan that is different than the Employee. For example, if the employee is enrolled in Kaiser HMO, the Dependent cannot be enrolled in Blue Care Network or MAP Plus. The Dependent may only be enrolled in the same plan that the Employee is enrolled in, in this example, Kaiser HMO.

5.2 Enrolling at the Beginning of Employment
To enroll for Program coverage upon hire, enroll on the Dow Benefits web site within 90 days of beginning to work or call the HR Service Center. If you are enrolling your Spouse/Domestic Partner and/or child(ren), you must provide proof of their eligibility within the 90-day period (for example: Marriage certificate, Domestic Partner signed statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate). If your enrollment and proof of Dependent eligibility are received within 30 days of your first day at work, coverage is effective on your first day on the job. Otherwise, except as specified below, coverage begins on the date your enrollment is received if the proofs of Dependent eligibility are received within 90 days of your first day at work and you are actively at work.

If you enrolled and submitted the required documentation during the 90-day period and you want your enrollment to be made retroactively effective to your date of hire, then you can request retroactive coverage. In order for your coverage to be made retroactive, you must pay 102% of the full cost to insure with post-tax dollars for the period from your date of hire until your date of enrollment.

Failure to provide proof of Dependent eligibility will result in no coverage for your Dependents.

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

**5.3 Enrolling During Annual Enrollment**

Enrollment is typically held during the last quarter of the year and is handled electronically. You can enroll for coverage, switch plans or waive coverage at this time. If you wish to add a Dependent, either a Spouse/Domestic Partner or a child, during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. Complete the Dependent Enrollment Change Form on the Dow Benefits web site or call the HR Service Center to add your Dependent, and submit it with proof of Dependent eligibility no later than March 31 of the applicable plan year.

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.

Failure to provide proof of Dependent eligibility will result in no coverage for your Dependents.

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

**5.4 Dual Dow Coverage**

If you and your Spouse/Domestic Partner are each independently eligible for coverage under a Dow-sponsored medical plan (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 active 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)
5.5 Special Enrollment Provisions

If you decline enrollment in Dow coverage for yourself or your Dependents (including your Spouse/Domestic Partner) because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependents outside of Dow’s usual open 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 Dow sponsored HMO/insured plan coverage, you or your eligible Dependent must enroll in the Dow sponsored HMO/insured plan coverage within 90 days after the other coverage ends. However, if you or your Dependent declined Dow sponsored HMO/insured plan coverage because of other coverage provided through COBRA, you or your Dependent must wait until Dow’s open 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. Proof of eligibility is required within the 90-day period.

If you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption or placement for adoption, you may receive Dow coverage for yourself and your Dependent if you enroll in the Dow coverage within 90 days after the Marriage, Domestic Partnership, birth, adoption or placement for adoption. For new births, the date of birth will be the effective date of coverage. For adoptions, the date of adoption or date of placement for adoption, whichever is earlier, will be the effective date of coverage. For Marriage and Domestic Partnership, coverage is effective on the date the Plan Administrator receives the enrollment papers. Proof of eligibility is required within the 90-day period.

If you or your Dependent either (i) lose coverage under Medicaid or a State Child Health Insurance Plan ("SCHIP") or (ii) become eligible for premium assistance under the Plan through Medicaid or SCHIP, you may receive coverage under the Plan for yourself and your Dependent if you enroll in the Plan within 90 days. Contact the HR Services Center, Employee Development Center, Midland, Michigan 48672, telephone (877) 623-8079 or (989) 638-8757. Plan coverage will be effective on the date the Plan Administrator receives the enrollment papers. Proof of eligibility is required within the 90-day period.

5.6 Change of Elections to Prevent Discrimination

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

If you move during the plan year and your HMO is not offered at your new location, you may switch your coverage to an HMO that is available at the new location or switch to a self-insured plan offered under The Dow Chemical Company Medical Care Program.

Section 6. Mid-Year Election Changes

6.1 Change in Status

You purchase your Employee, Spouse and Dependent Child coverage with premiums that are pre-tax dollars through The Dow Chemical Company Flexible Spending Plan, a plan intended to qualify under s.125 of the Internal Revenue Code as a “Cafeteria Plan.” Under Internal Revenue Service (IRS) rules, you may change your medical coverage level only during annual enrollment or if you have BOTH a “change in status” AND you meet all of the consistency rules. Because of IRS rules, Domestic Partner coverage is purchased with post-tax dollars. The Program administers changes in status events and the consistency rules the same way with respect to Domestic Partners as Spouses, regardless of the post-tax treatment by IRS, to the extent that such administration does not jeopardize the tax qualified status of the Program.

A “change in status” is an event listed in one of the bullets below:
- Events that change your legal marital status, including Marriage, Domestic Partnership, death of Spouse/Domestic Partner, divorce or annulment or similar event with respect to a Domestic Partnership.
- Birth, adoption, placement for adoption or death of Dependent.
- A termination or commencement of employment by you or your Spouse/Domestic Partner.
- A reduction or increase in hours of employment by the Employee or Spouse/Domestic Partner.
- Dependent satisfies or ceases to satisfy the definition of “Dependent child.”
- A change in the place of residence or work for you or your Spouse/Domestic Partner.
- Spouse/Domestic Partner gains eligibility for coverage under the Spouse/Domestic Partner’s employer’s health plan.

6.2 Consistency Rule

Consistency Rule:

In addition to having a “change in status,” you also must meet all of the following consistency rules.

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

2. The election change to the Dow sponsored plan must correspond with that gain or loss of coverage.

Exceptions:

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 QMCSO), requires a change in your medical plan election.
Entitlement to Medicare or Medicaid – If you, your Spouse/Domestic Partner or Dependent are enrolled in the Program and become entitled to coverage (i.e., enrolled) under Medicare or Medicaid mid-year (other than for coverage consisting solely for distribution of pediatric vaccines), you may cancel your Program coverage.

Significant Cost or Coverage Changes – If your Spouse/Domestic Partner is covered by his/her employer’s plan, and your Spouse/Domestic Partner’s employer allows him/her to change his/her benefit plan election because of a significant change in cost or coverage under your Spouse/Domestic Partner’s employer’s plan, such change in your Spouse/Domestic Partner’s election will allow you to change your Dow election. If your Spouse/Domestic Partner’s employer’s enrollment period is different from Dow’s, your Spouse/Domestic Partner’s election under his/her employer’s plan may constitute a significant coverage change allowing you to change your Dow election.

Special Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA) – You may change your Program election mid-year if you meet the special enrollment requirements addressed in HIPAA. See the HIPAA section for more details.

6.3 Documentation of Eligibility Required to Make Election Change

Documentation is required to make an election change, such as birth certificates, passports, Marriage certificates, Domestic Partner signed statements, evidence of loss of Spouse/Domestic Partner or Dependent’s employment, or any other form of proof the Plan Administrator deems appropriate. The Program reserves the right to, at any time, request proof of eligibility.

Failure to provide proof of eligibility within the time required will result in no coverage.

6.4 Deadline to Enroll for Mid-Year Changes

If you meet the requirements allowing you to make a mid-year election change, any change made at any time outside of open enrollment (typically in the Fall of each year), you must submit proof of eligibility and enroll within 90 days or 180 days for geographic relocation under the Participating Employer’s relocation policy of the change in status event.

Except for the birth or adoption of a child or a court order, if the Plan Administrator receives your enrollment and proofs within 31 days of the Change-in-Status event, the effective date of change in coverage will be the date of the Change in Status event. If the Plan Administrator receives your enrollment and proofs on day 32 through 90 after the Change in Status event, the effective date of the change in coverage will be the Plan Administrator’s processing date. For the birth of a child, the date of birth will be the effective date of coverage. For adoption of a child, the date of adoption or date of placement for adoption, whichever is earlier, will be the effective date of coverage. For a court order, the date specified in the court order will be the effective date.
Section 7. Premiums

7.1 Your Contribution

You and Dow share the premium costs for your medical coverage. The Employee portion of the premiums is paid through payroll deductions. For the Employee portion of the monthly premium, refer to the annual enrollment communication materials provided during the annual enrollment period to determine the applicable Employee premium. The amount you pay, through payroll deduction, is the difference between the total cost of HMO/insured plan coverage and Dow’s contribution. Contributions for coverage for you, your Spouse and your Dependent Children are deducted on a pre-tax basis. Because of IRS regulations, contributions for Domestic Partner coverage are deducted on a post-tax basis. You may change plan contributions only at the end of a plan year or within 90 days or 180 days for geographic relocation under Dow’s relocation policy of a change in status if you meet the other Change in Status and consistency rule requirements of this SPD. Therefore, if you have a status change that would affect your contribution (i.e., Marriage, Domestic Partnership, divorce, Termination of a Domestic Partnership, birth, adoption, death of a Dependent or a change in eligibility for a Spouse or Dependent child), you must complete a new enrollment within 90 days or 180 days for geographic relocation under Dow’s relocation policy of the change. Otherwise, your contribution may not be changed until the next annual enrollment period, effective at the beginning of the next calendar year. The Program administers changes in status events and the consistency rules the same way with respect to Domestic Partners as Spouses, regardless of the post tax treatment by the IRS, to the extent that such administration does not jeopardize the tax qualified status of the Program.

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

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

7.2 Excess Premium Payments

If you enrolled for Dependent coverage and failed to provide proof of Dependent eligibility satisfactory to the Plan Administrator within the required time period, or the Plan Administrator determines that your Dependent(s) is or are not covered, the Program reserves the right not to refund the premiums you paid, and to cancel coverage of your Dependent(s) if the Plan Administrator determines that coverage was obtained through fraud or intentional misrepresentation of material fact.
7.3 Premiums During a Benefits Protected Leave of Absence

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

If a Participant goes on an approved unpaid leave of absence under the Participating Employer's Family or Medical Leave Policy, then the Plan Administrator will continue to maintain the Participant's Plan Benefits during the approved leave on the same terms and conditions as if the Participant were still an active Employee. The Participant must pay his share of the premium in one of the following ways. The Participant must provide written notification to the Plan Administrator at least two (2) weeks prior to the beginning of the leave as to which method of payment the Participant selects; otherwise method three (3) is the default method.

- With after-tax dollars, by sending monthly payments to the Plan Administrator by the due date established by the Plan Administrator.
- With pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation.
- The Employer may fund coverage during the leave and withhold "catch up" amounts upon the Participant’s return.
- Under another arrangement agreed upon between the Participant and the Plan Administrator.

If the Participant's coverage ceases while on family or unpaid medical leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis as the participant was participating in the Plan prior to the leave.

Section 8. Survivor Benefits

8.1 Survivor Benefits

General Rule
Generally, a surviving Spouse/Domestic Partner of an active Employee is eligible for 36 months of COBRA coverage if he or she was covered under a Plan at the time of death. See section entitled Ending Coverage of this SPD for information about COBRA coverage.

Exception for Vested Participants of the Dow Employees’ Pension Plan or Union Carbide Employees’ Pension Plan
There is an exception to the general rule for surviving Spouses/Domestic Partners of vested participants of the Dow Employees’ Pension Plan and Union Carbide Employees’ Pension Plan; provided the deceased was hired prior to January 1, 2008. Check the applicable Dow or UCC retiree medical summary plan description for eligibility requirements for surviving spouses, or call the Retiree Service Center.

Exception for Vested Participants of the Rohm and Haas Company Retirement Plan
There is an exception to the general rule for surviving Spouses/Domestic Partners of vested participants of the Rohm and Haas Company Retirement Plan; provided the deceased was hired prior to January 1, 2003 and met the Rule of 65 requirements.

Your surviving Spouse/Domestic Partner can obtain a copy of the applicable retiree medical SPD from the Dow HR Service Center at (877) 623-8079 or (989) 638-8757. The retiree
medical SPD provides eligibility and cost information about the coverage available to survivors. If your surviving Spouse/Domestic Partner is enrolled for coverage under an applicable retiree medical plan, your surviving Dependent Child(ren), including your biological child in utero, also may be covered. They must meet the Dependent eligibility requirements. If your surviving Spouse/Domestic Partner works full time, he/she must enroll your children in any group medical coverage offered by his/her surviving Spouse/Domestic Partner’s employer.

**Surviving Children without Surviving Spouse/Domestic Partner**

If there is no surviving Spouse/Domestic Partner, your surviving child(ren) who were eligible for coverage at the time of your death will be able to receive continued coverage for up to 36 months. This coverage meets the requirements of, and runs concurrently with, the coverage required under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Dow will subsidize the COBRA premiums for the first 12 months. Your surviving Dependent Child(ren) will be eligible for coverage under the HMO/insured plan with premiums applicable to active Employees for up to one year after the date of your death. They must enroll and pay the applicable premiums within the time specified by the Plan Administrator. 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. Again, in order to be covered, they must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.

### Section 9. HIPAA and Other Laws

#### 9.1 Health Insurance Portability and Accountability Act (HIPAA) and Other Legislation

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 require the following:

**Women’s Health and Cancer Rights Act of 1998:**

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

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

**Maternity Stays:**

Group health plans and health insurance issuers cannot, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child of 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 the issuer for prescribing a length of stay up to 48 hours or 96 hours as applicable.
Certificates of Coverage:

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

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

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 HMOs and insured plans under contract with Dow and the Plan Administrator for purposes of administering the Program. Aggregate data and summary health information, as defined by HIPAA, may be used by the Plan Sponsor to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with the Company and/or Plan Administrator to protect individually identifiable health information in accordance with HIPAA by the time required by 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 10. Filing a Claim

10.1 Filing Claims and Appealing Claims Denials

If you want to file a Claim for a Plan Benefit or appeal the denial for a Claim for Plan Benefit, take a look at the written materials provided to you by your HMO. You can also contact your HMO. If you need help contacting your HMO, you can call Secova for assistance at 1-800-7DOWDOW. If you want to file a Claim for an Eligibility Determination or appeal the denial of eligibility, see the Claims Procedures section of this SPD Wrapper.

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.

A Claim for Plan Benefits is a Claim requesting that the applicable Plan pay for benefits covered under the applicable Plan.
Section 11. Fraud Against the Program

11.1 Fraud Against the Program

Any Participant who intentionally misrepresents information to the Program or an HMO/insured plan or knowingly misinforms, deceives or misleads the Program or an HMO/insured plan, or knowingly withholds relevant information, may have his/her coverage cancelled retroactively to the date deemed appropriate by the Plan Administrator. Further, such Participant may be required to reimburse the HMO/insured plan for Claims paid by the HMO/insured plan. The Program or the HMO/insured plan may choose to pursue civil and/or criminal action. The Plan Administrator may determine that such Participant and the covered Dependents are no longer eligible to participate in the Program because of the Participant’s actions. In addition, if the Participant (who could be the Employee) and the covered Dependents are terminated from eligibility under any benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that the Participant and all Dependents are not eligible for coverage under the Program.

Section 12. Ending Coverage

12.1 When Coverage Ends

Coverage ends when any of the following occurs:

- The Participant or Dependent no longer meets the eligibility requirements
- Death
- Termination of the Plan or Program
- Failure to pay the required premiums
- Failure to reimburse the Program for claims paid by the program that under the terms of the Program, you or your Dependent are required to reimburse the Program
- Failure to comply with the terms and conditions of the Program
- Providing false or misleading information to the Program

When your Dependent is no longer eligible, or dies, update your enrollment information on the Dow Benefits web site or contact the HR Service Center at (877) 623-8079 or in Midland at (989) 638-8757 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 the date you update your enrollment information on the Dow Benefits web site or contact the HR Service Center to update your enrollment information.

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.

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 can become available to you and to other members of your family who are covered under the Program when you would otherwise lose your group health coverage.
Although COBRA does not apply to Domestic Partners, the Program will provide Domestic Partners the same protection it provides Spouses that are covered under COBRA, consistent with the applicable Program’s definition and rules concerning Domestic Partners, and to the extent that it does not jeopardize the tax qualified status of the Program.

The Plan Administrator of the Program is the N.A. Health and Welfare Leader of The Dow Chemical Company. The Plan Administrator can be contacted:

N.A Health and Welfare Leader
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
(877) 623-8079 or (989) 638-8757

COBRA continuation coverage for the Program is administered by Towers Watson’s BenefitConnect COBRA product. BenefitConnect can be contacted:

BenefitConnect COBRA Service Center
PO 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, and your Dependent children could become qualified beneficiaries if coverage under the Program is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your Spouse dies;
(2) Your Spouse’s hours of employment are reduced;
(3) Your Spouse’s employment ends for any reason other than his or her gross misconduct (only applicable to active employees working for a Participating Employer);
(4) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced from your Spouse.
Your Dependent children will become qualified beneficiaries if they lose coverage under the Program because any of the following qualifying events happens:

(1) The parent-Employee dies;
(2) The parent-Employee’s hours of employment are reduced (only applicable to active Employees working for a Participating Employer);
(3) The parent-Employee’s employment ends for any reason other than his or her gross misconduct (only applicable to active Employees working for a Participating Employer);
(4) The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced; or
(6) The child stops being eligible for coverage under the Program as a “Dependent child.”

When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Dow’s 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 of the Employee and Spouse 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 HR Service Center. In addition, you must complete and submit the forms described below within the time required. See telephone numbers listed above for the Plan Administrator. Written notice is required for 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 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 the qualifying event is a Dependent child’s loss of eligibility for coverage under a Program, you must complete a Change in Status Form that can be obtained from the Dow Benefits web site or by requesting one from the Plan Administrator. In addition, you must complete a Dependent Qualifying Event letter, which can 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 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 the Employee and the Employee’s Spouse may elect continuation coverage, or only one of them. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. A qualified beneficiary must elect in writing within 60 days of being provided a COBRA election notice, using Dow’s COBRA Administrator’s election form and following the procedures specified on the election form. Your written notice must be provided to Dow’s COBRA Administrator at the address provided on the election form and following the procedures specified on the election form. If you mail your election, it must be postmarked no later than the last day of the 60-day election period. If you or your Spouse or Dependent children do not elect continuation coverage within this 60 day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

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

Medicare Extension for Spouse and Dependent Children

When the qualifying event is the end of employment or reduction of the Employee’s hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and written notice is provided to Dow’s COBRA Administrator by the time specified below, the qualified beneficiary may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The qualifying event must have been the end of employment or a reduction of the Employee’s hours of employment. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You or the qualified beneficiary must provide written notice to Dow’s COBRA Administrator and a copy of the written determination of disability from the Social Security Administration to Dow’s COBRA Administrator at the address indicated above within 60 days of the date of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The employer can charge up to 150% of the group rate during the 11-month disability extension. You or the qualified beneficiary must notify Dow’s COBRA Administrator at the address indicated above within 30 days upon the determination that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act. If these procedures are not followed or if the notice is not provided in writing to Dow’s COBRA Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.
Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

Continuation coverage will be terminated 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; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

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

Cost of Continuation Coverage

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 (or, in the case of continuation coverage due to disability, 150%).

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 Dow’s 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 that 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 Dow’s 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 Dow’s 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. Dow’s COBRA Administrator will send you payment coupons for payments due for these coverage periods. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive payment coupons.

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 Employee during COBRA Period**

A child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. 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 of the covered Employee who is receiving benefits under a Program pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered Employee’s period of employment with the employer is entitled to the same rights under COBRA as a Dependent child of the covered Employee, regardless of whether that child would otherwise be considered a Dependent.

**Governmental Assistance from Trade Act of 2002**

The Trade Act of 2002 created special trade adjustment assistance for certain groups of individuals who have been certified by the U.S. Department of Labor, or a State agency, as having lost their jobs because
of international trade competition. In addition, in order to be eligible for trade adjustment assistance from the government you must meet the following requirements:

- You must be receiving a trade readjustment allowance from the government under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- You must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance from the government;
- You must not have elected COBRA during the regular COBRA election period available to you as a result of your termination of employment or reduction in hours.

Under the new tax provisions, eligible Trade Act individuals can either take a tax credit or get advance payment from the government of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp

If You Have Questions

Questions about any of the Programs or your COBRA continuation coverage rights should be addressed to the Plan Administrator or Dow’s 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, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/elsa.

Keep Your 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. Your Legal Rights Under ERISA

When you are a Participant in The Dow Chemical Company Insured Health 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, the Plan Document, other documents governing the Program, and the latest annual report filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of the Plan Document and Summary Plan Descriptions. The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Program’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- 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. Review this SPD’s *Ending Coverage* section for more information.

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 and the HMO/insured plans, called “fiduciaries”, have a duty to act prudently and in the interest of you and other Participants and beneficiaries. If it should happen that fiduciaries misuse any of the Program’s money, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. Under the terms of this Program, if you file a lawsuit, you must do so within 120 days from the date of the alleged misuse. Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit.

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

**Enforce your rights:** If you have a Claim for 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 just described. 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 which is denied or ignored, in whole or in part, you must file a written appeal within the time period specified in the claims procedures. Failure to comply with the claims procedures may significantly jeopardize your rights to benefits. If you are not satisfied with the final appellate decision, you may file suit in federal court. In addition, if you disagree with the Plan Administrator’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

**Deadline to file a lawsuit:** Under the terms of this Program, if you file a lawsuit, you must do so within 120 days from the date of the Claims Administrator’s or the Plan Administrator’s final written decision (or the deadline the Claims Administrator or Plan Administrator had to notify you of a decision). Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

**Assistance with your questions:** If you have any questions about the information in this SPD Wrapper 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 your HMO/insured plan. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.
Section 14. Plan Administrator’s Discretion

The Plan Administrator is a fiduciary to the Program. Except for the duties reserved to the Claims Administrator, the Plan Administrator has the full and complete discretion to interpret and construe all of the provisions of the Program. Such interpretation of the provisions of the Program shall be final, conclusive and binding. Except for the duties reserved to the Claims Administrator, the Plan Administrator also has the full and complete discretion to make findings of fact. The Plan Administrator has the full authority to apply those findings of fact to the provisions of the Program. All findings of fact made by the Plan Administrator shall be final, conclusive and binding. For a detailed description of the Plan Administrator’s authority, see the Plan Document. See section 23 for information about the Claims Administrator’s discretion.

Section 15. Welfare Benefits

Welfare benefits, such as The Dow Chemical Company Insured Health Program, are not required to be guaranteed by a government agency.

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

The Dow Chemical Company reserves the right to amend, modify or terminate The Dow Chemical Company Insured Health Program (and/or its inclusion or exclusion of any HMO or insured plan) at any time at its sole discretion. The procedures for amending, modifying and terminating the Program are contained in the Plan Document.

Section 17. Disposition of Plan Assets If the Program is Terminated

The Company may terminate The Dow Chemical Company Insured Health Program at any time at its sole discretion. If the Company terminates the Program, the assets of the Program, if any, shall not be used for the benefit of the Company, but may be used to:

- provide benefits for Participants in accordance with the Program, and/or
- pay third parties to provide such benefits, and/or
- pay expenses of the Program and/or the trust (if any) holding the Program's assets, and/or
- provide cash for Participants, as long as the cash is not provided disproportionately to officers, shareholders, or highly compensated Employees.
Section 18. Class Action Lawsuits

Legal actions against the Plan must be filed in U.S. federal court. Class action lawsuits must be filed either 1) in the jurisdiction in which the Plan is administered (Michigan) or 2) the jurisdiction in the United States of America where the largest number of putative members of the class action reside. This provision does not waive the requirement to exhaust administrative remedies before the filing of a lawsuit.

Section 19. Funding

The Company shares the premium costs with the Participants. Employee contributions are made through payroll deductions. Benefits are underwritten by the respective HMO’s. 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 may be amended from time to time, as well as to pay expenses of the Program. Such expenses may include, and are not limited to consulting fees, actuarial fees, attorney’s fees, third party administrator fees and other administrative expenses.

Section 20. Payment of Unauthorized Benefits

If the Plan Administrator determines that benefits in excess of the amount authorized under the Program were provided to a Participant, Dependent or other person:

- The amount of any other benefit paid to such Participant, Dependent or other person under the Program shall be reduced by the amount of the excess payment; and/or
- The Plan Administrator may require the Participant, Dependent or other person to reimburse the Program; and or
- 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

Section 21. For More Information

For more information regarding the provisions in this SPD Wrapper, please contact the Dow HR Service Center at (877) 623-8079, or at (989) 638-8757 in Midland, Michigan, with any questions. For information about benefits covered under a specific HMO or insured plan, or claims for HMO/insured plan benefits, contact the specific HMO. If you need help in finding an address or phone number for your HMO, contact Secova at 1-800-7DOWDOW.
Section 22. Definitions of Terms

The following are some of the defined terms of The Dow Chemical Company Insured Health Program. Additional terms are defined in the Plan Document for The Dow Chemical Company Insured Health Program. Capitalized words refer to terms defined in this SPD or in the Plan Document. A copy of the Plan Document is available upon request of the Plan Administrator. See the ERISA Information Section for the Plan Administrator’s name and address.

Active Employee Points
“Active Employee Points” means the sum of the employee’s age and years of service recognized under the Company’s service award policy.

Appeals Administrator
The Appeals Administrator with respect to reviewing an adverse Claim for Benefits is the applicable HMO. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the N.A. Health and Welfare Leader for The Dow Chemical Company.

“Bargained-for Individual” or “Bargained-for Employee”
An individual who is represented by a collective bargaining unit that is recognized by the Participating Employer. “Bargained-for Employee” and “Hourly Employee” have the same meaning.

Claim
A written request by a claimant for a benefit under the HMO or insured plan or an Eligibility Determination that contains, at a minimum, the information described in the Claims Procedures Appendix (APPENDIX B).

Claim for Eligibility Determination
A Claim requesting a determination as to whether a claimant is eligible to be a Participant under an HMO or insured plan.

Claim for Plan Benefits
A Claim requesting that the HMO or insured plan pay for benefits covered under the HMO or insured plan. A “Claim for Eligibility Determination” does not include a request for determination of eligibility under the Plan’s COBRA provisions.

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) that allows a member or Dependent to stay enrolled in the Program for a limited time after coverage for that person would ordinarily cease. Some states have similar statutes that apply to the HMO or insured plans that do business in those states.

Company
The Dow Chemical Company.
Creditable Coverage
With respect to HIPAA, coverage under The Dow Chemical Company Insured Health Program, Medicare, Medicaid, or any other group health, individual health or other health insurance coverage described in 29 CFR s. 2590.701-4.

Credited Service
Credited service recognized under the Dow Employees’ Pension Plan.

Dependent
An Employee’s Spouse or Domestic Partner, or a Dependent child (as defined below).

Dependent Child
A “Dependent child” is a child who must be:

- your birth or legally adopted child, or
- your Spouse’s or Domestic Partner’s natural or adopted child; or
- a child for whom you or your Spouse or your Domestic Partner have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the first 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, and
  - authority to enlist the child in the armed forces of the U.S.; and
  - 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 a “Dependent child”, the child must be less than age 26, except that a child who is age 26 or older and incapable of self-sustaining employment because of a physical or mental disability, and is covered under the Plan prior to the child’s 26th birthday, may continue coverage.

Domestic Partner
A person who is a member of a Domestic Partnership.

Domestic Partnership
Two people claiming to be "domestic partners" who meet all of the following requirements of paragraph A, or the requirements of paragraph B:

A.
1. the two people must have lived together for at least twelve (12) consecutive months immediately prior to receiving coverage for benefits under the Plan, and
2. the two people are not Married to other persons either now, or at any time during the twelve month period, and
3. during the twelve month period, and now, the two people have been and are each other's sole domestic partner in a committed relationship similar to a legal Marriage relationship and with the intent to remain in the relationship indefinitely, and
4. each of the two people must be legally competent and able to enter into a contract, and
5. the two people are not related to each other in a way which would prohibit legal Marriage between opposite sex individuals, and
6. in entering the relationship with each other, neither of the two people are acting fraudulently or under duress, and
7. during the twelve month period and now, the two people have been and are financially interdependent with each other, and  
8. each of the two people have signed a statement acceptable to the Plan Administrator and have provided it to the Plan Administrator.

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

Dow  
When used in this SPD and other communications to Employees, “Dow” refers to The Dow Chemical Company and its subsidiaries and affiliates that it has authorized to participate in the Program. “Dow” and “Participating Employers” have the same meaning and are used interchangeably.

“Dow Insured Health Program” or “Insured Health Program”  
The Dow Chemical Company Insured Health Program

Eligibility Determination Claims  
Claims requesting a determination as to whether a claimant is eligible to be a Participant under the HMO or insured 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; and
- receives a payment for Services performed for the Participating Employer directly from a Participating Employer’s U.S. Payroll Department, and
- is either a Salaried individual who is classified by the Participating Employer as having regular Full-Time status, a Salaried individual who is classified by the Participating Employer as having active Less-Than-Full-Time active status, or is a Bargained-for Individual who is classified by the Participating Employer as having regular Full-Time active status; and
- if Localized, is Localized in the U.S.; and
- if on an international assignment, is a U.S. citizen or Localized in the U.S.

The definition of “Employee” does not include an individual who performs Services for the benefit of a Participating Employer if his compensation is paid by an entity or source other than a Participating Employer’s U.S. Payroll Department. Further, the definition of “Employee” does not include any individual who is characterized by the Participating Employer as an independent contractor, contingent worker, consultant or contractor. These individuals are not “Employees” (with a capital “E”) for purposes of the Plan even if such individual(s) is determined by a court or regulatory agency to be a “common law employee” of a Participating Employer.

Full-Time  
An Employee classified by the Participating Employer as having Full-Time status.
**Highly Compensated Employee**
Any person who is a “highly compensated employee” as such term is defined in section 414 (q) of the U.S. Internal Revenue Code.

**HIPAA**
The Health Insurance Portability and Accountability Act.

**HMO**
Health Maintenance Organization.

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

**Initial Claims Reviewer**
The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the applicable HMO. The Initial Claims Reviewer with respect to deciding a Claim for an Eligibility Determination is the N.A. Health and Welfare Leader.

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

**Localized**
“Localized” means that a Participating Employer has made a determination that an Employee is permanently relocated to a particular country, and the Employee has accepted such determination. For example, 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 (ERISA Plan #606).

**LTD Participant**
A former Employee who is receiving a long term disability payment from LTD who meets the eligibility requirements of the Program.

**Marriage**
A civil contract between a man and a woman. The man and woman must have the legal capacity to marry, and the contract must have been formalized by a marriage license with formalities similar to and consistent with the requirements for a valid marriage in the state of Michigan. The Plan does not recognize common law marriages except that: (a) if an Employee was a participant of a plan of The Dow Chemical Company Medical Care Program before November 1, 1993, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a Dow Medical Plan before November 1, 1993, then such common law Spouse is deemed under the Program to be Married to the Employee; (b) effective January 1, 1996, the Plan recognizes a marriage that meets the requirement of Texas Family Code Annotated s. 2.402; and (c) effective January 1, 2002, common law Spouses of UCC employees and former UCC employees who were covered under a UCC medical plan at any time between February 5, 2001, and December 31, 2001, as “spouses” of UCC employees will be deemed to be “Married” for purposes of the Program.

**Medicare**
The “Health Insurance for the Aged and Disabled” provisions of the Social Security Act of the U.S. as it is now and as it can be amended.
**Medicare Modernization Act**

**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 s. 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 HMO plans that provide prescription drug coverage.

**Medicare prescription drug plan**
A prescription drug plan that has been approved as specified in 45 CFR s. 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 HMO plans that provide prescription drug coverage.

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

**N.A. Health and Welfare Leader**
The North America Health and Welfare Leader for The Dow Chemical Company.

**Participant**
An Employee who is covered under the applicable HMO or insured plan, or any other individual who is continuing coverage under COBRA.

**Participating Employer**
The Dow Chemical Company or one of its subsidiaries that has been authorized by The Dow Chemical Company to participate in the Program. “Participating Employers” and “Dow” have the same meaning and are used interchangeably.

**Plan**
The HMO or insured product that provides coverage from the HMO or insurance carrier. There are many “Plans” offered through HMO’s and insurance carriers under The Dow Chemical Company Insured Health Program.

**Plan Administrator**
Each of the Vice President of Compensation and Benefits, Associate Director of North America Benefits, and the N.A. Health and Welfare Leader, and such other person, group of persons or entity which may be designated by The Dow Chemical Company in accordance with the Plan Document.

**Plan Document**
The plan document for The Dow Chemical Company Insured Health Program, which is ERISA Plan #601. The summary plan descriptions for the plans offered under the Program are integral parts of the Plan Document for the Program.

**Plan Sponsor:**
The Dow Chemical Company
Program
The Dow Chemical Company 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 (see the ERISA Section of this SPD).

Regular Employee
A “regular” Employee is an Employee who is not classified by the Employer as a seasonal or temporary.

“ROH” or “Rohm and Haas”
Rohm and Haas Company and certain of its subsidiaries.

Salaried Individual
An individual who is not represented by a collective bargaining unit.

Significant Break In Coverage
Sixty-three (63) consecutive days during which an individual does not have any Creditable Coverage under HIPAA.

Spouse
A person who is Married to the Employee. See the definition of Marriage for further details.

Spouse/Domestic Partner
Refers to a Spouse or Domestic Partner, whichever is applicable. References to “Spouse/Domestic Partner” are applicable to active Employees. The term, “Spouse/Domestic Partner”, does not apply to Retirees, 60 and 65 Point Retiree Medical Severance Plan Participants, and LTD Participants.

Summary Plan Description (“SPD”)
The summary plan description for The Dow Chemical Company Insured Health Program, including its appendices. The summary plan description is an integral part of the Plan Document.

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

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

U.S.
The United States of America.

Vice President of Compensation and Benefits
The Vice President of Compensation and Benefits for The Dow Chemical Company.
Section 23. Claims Procedures

These Claims procedures are part of The Dow Chemical Company Insured Health Program Summary Plan Description (SPD). They only address Claims for an Eligibility Determination (see definition). For Claims for Plan Benefits, see the information provided by your HMO or insured plan. If you no longer have a copy of the information provided by your HMO or insurance plan, contact your HMO or insurance plan. You may contact Secova for assistance in obtaining the address of your HMO or insurance plan. See ERISA Information section of this SPD for Secova’s address and phone number.

23.1: General

A “Claim” is a written request by a claimant for a plan benefit or an Eligibility Determination that contains, at a minimum, the information described below, and is addressed and delivered to the applicable Administrator. A Claim for a Plan benefit is a written request that the plan pay for benefits covered under the HMO or insured plan. A Claim for an Eligibility Determination is a written request for a determination as to whether a claimant is eligible to participate in the Program.

23.2: Who Will Decide Whether to Approve or Deny My Claim?

The Program has more than one Claims Administrator. Each of the Claims Administrators is a named fiduciary of the Program with respect to the respective types of Claims that they process. The applicable Claims Administrator will make the decision as to whether to approve or deny your Claim.

Claims for an Eligibility Determination: The initial determination for a Claim for an Eligibility Determination is made by the Initial Claims Reviewer. The Initial Claims Reviewer is the N.A. Health and Welfare Leader for The Dow Chemical Company. The initial eligibility determination is made by the Initial Claims Reviewer. If you appeal, the appellate decision is made by the Associate Director of North America Benefits for The Dow Chemical Company. The Associate Director of North America Benefits is the Appeals Administrator.

Claims for a Plan Benefit: The applicable Claims Administrator for determinations of whether a Claim for Plan Benefits is payable under the provisions of the HMO or insured plan for both the initial determination and (if you appeal) the appellate determination is the applicable HMO or insured plan. If you have trouble contacting the HMO, contact Secova for assistance. See ERISA Information section of this SPD for Secova’s address and phone number.

Authority of Administrators and Your Rights Under ERISA:

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to the review by the Appeals Administrator). After you have appealed the initial determination, if you are not satisfied with the Appeals Administrator’s final written decision, you can file a civil action against the HMO or insured plan, or the Program under s.502 of the Employee Retirement Income Security Act (ERISA) in federal
court. If you file a lawsuit, you must do so within 120 days from the date of the Appeals Administrator’s final written decision. Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit.

23.3: An Authorized Representative Can Act on Your Behalf

An authorized representative can 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. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition also may act as your authorized representative.

23.4: Claims for Benefits

Filing a Claim for Benefits

You must file a Claim for Benefits with your specific HMO or insured plan. You must follow your HMO or insured plan’s claims procedures, which are contained in the information provided to you by your HMO or insured plan.

Appealing a Denial of a Claim for Benefits

If you want to appeal your HMO or insured plan’s decision to deny your Claim for Benefits, you should follow the appeals procedures of your HMO or insured plan. These appeals procedures are contained in the information provided to you by your HMO or insured plan.

23.5: Eligibility Determination Claims

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

- the name of the person who is requesting an eligibility determination,
- the benefit plan for which the eligibility determination is being requested,
- the relationship of the person requesting eligibility determination in relation to the Employee, and
- documentation of such relationship.

Claims for eligibility determinations must be sent to:

N.A. Health and Welfare Leader
The Dow Chemical Company
U.S. Benefits Center
Employee Development Center
Midland, Michigan 48674
Attention: Initial Claims Reviewer for The Dow Chemical Company Insured Health Program

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.

Appealing the Initial Determination:

If the Initial Claims Reviewer has denied your Claim, you can 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 Associate Director of North America Benefits. Your written appeal must include the following
information:
- your name,
- name of the Plan,
- reference to the initial determination, and
- explanation of the reason why you are appealing the initial determination.

Appeals of eligibility determination Claims 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 Dow Chemical Company Insured Health Program
(Appeal of Eligibility Determination)

You can submit any additional information to the Associate Director of North America Benefits when
you submit your request for appeal. You also may request that the Plan Administrator provide you
copies of documents, records and other information that is relevant to your Claim, as determined by the
Associate Director of North America Benefits under applicable federal regulations. Your request must
be in writing. Such information will be provided at no cost to you.

After the Associate Director of North America Benefits receives your written request to appeal the initial
determination, the Associate Director of North America Benefits will review your Claim. Deference
will not be given to the initial adverse decision, and the appellate reviewer will look at the Claim anew.
The Associate Director of North America Benefits is not the same person as the person who made the
initial decision to deny the Claim. In addition, the Associate Director of North America Benefits is not a
subordinate who reports to the person who made the initial decision to deny the Claim. The Associate
Director of North America Benefits 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 Associate Director of North America Benefits can have up to
an additional 60 days to provide written notification of the final decision. If the Associate Director of
North America Benefits 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 the Associate Director of North America Benefits determines that it does not have
sufficient information to make a decision on the Claim prior to the expiration of the initial 60-day period,
it will notify you. It will describe any additional material or information necessary to submit to the Plan,
and provide you with the deadline for submitting such information.

The initial 60-day time period for the Associate Director of North America Benefits to make a final
written decision, plus the 60-day extension period (if applicable) are tolled from the date the notification
of insufficiency is sent to you until the date on which it receives your response. (“Tolled” means the
“clock or time is stopped or suspended.” In other words, the deadline for the Associate Director of North America Benefits to make its decision is “put on hold” until it receives the requested information.) The tolling period ends when the Associate Director of North America Benefits receives your response, regardless of the adequacy of your response.

If the Associate Director of North America Benefits denies the Claim or appeal, the Associate Director of North America Benefits will send you a final written decision that states the reason(s) why the Claim you appealed is being denied and refer to the pertinent Plan provisions.

Section 24. For More Information

For more information regarding the provisions in this SPD, please contact the Dow HR Services Center (if you are an Employee) or the Retiree Service Center (if you are a Retiree) using the contact information contained in the ERISA Information section of this SPD.
APPENDIX A. Important Notice of Creditable Coverage for Medicare-Eligibles

Applicable to Plan Year 2012

The Dow Chemical Company Insured Health Program does provide Creditable Coverage for prescription drugs for the following plans:

- Triple S Plan
- All health maintenance organizations (HMO’s) participating in The Dow Chemical Company Insured Health Program that are available for those who are not eligible for Medicare (“Dow-approved HMO’s”)

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

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

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 Dow Chemical Company has determined that the prescription drug coverage offered by the Triple S Plan and all Dow 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 Dow coverage will be affected. If you enroll in Medicare prescription drug coverage (other than a Medicare Advantage-PD Plan offered through The Dow Chemical Company Insured Health Program), you will be disqualified from participation in any Retiree medical and prescription coverage sponsored by The Dow Chemical Company while you are enrolled in the Medicare prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Dow coverage, be aware that you and your dependents will be able to get this coverage back during The Dow Chemical Company annual enrollment period.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: Fall, 2011
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 or (989) 636-0977