

Summary Plan Description for:

The International Medical and Dental Plan of

The Dow Chemical Company Insured Health Program

Amended and Restated: January 1, 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Effective January 1, 2012 and thereafter until superseded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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INTRODUCTION

This is the Summary Plan Description ("SPD") for the International Medical and Dental Plan ("Plan"), which is one of the plans of The Dow Chemical Company Insured Health Program ("Program"). The Plan first became effective on July 1, 2002.

This document is intended to constitute the "Summary Plan Description" for the Plan. However, it does not contain all of the information about the Plan. This SPD is an integral part of the Plan Document for The Dow Chemical Company International Medical and Dental Plan. Further information can be found in the Plan Document for The Dow Chemical Company Insured Health Program (a copy of which is available from the Plan Administrator), and the Certificate of Insurance (a copy of which is inserted in the side pocket of this SPD, or if you are accessing on the Dow Intranet, you may request a copy from CGLIC or the Plan Administrator). If there is a discrepancy between this SPD and the Plan Document and the Certificate of Insurance, the Certificate of Insurance will have priority over the Plan Document and SPD, and the Plan Document will have priority over the SPD. You may request a copy of the Plan Document or the Certificate of Insurance from the Plan Administrator. See Section 1 of this SPD entitled "*ERISA Information*" for the Plan Administrator's name and address.

The Dow Chemical Company reserves the right to amend, modify or terminate the International Medical and Dental Program (and/or any underlying plans) at any time at its sole discretion.

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

Words that are capitalized are either defined in the Plan Document for the Program or in Section 17 of this SPD, entitled "*Definitions*". When used in this Summary Plan Description and communications to Employees, "Dow" refers to The Dow Chemical Company, and certain of its subsidiaries and affiliates that The Dow Chemical Company has authorized to participate in this Plan.

Section 1. ERISA INFORMATION

Plan Sponsor:	The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Plan Administrator:	Senior International Benefits Manager The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Employer Identification Number:	38-1285128
CGLIC Insurance Policy Number:	02002A
Plan Number:	601
Claims Administrator:	<p>With respect to claims and questions concerning benefits coverage: CIGNA International Service Center P.O. Box 15050 Wilmington, DE 19850 U.S.A. 1.800.441.2668 or 1.302.797.3100 (reverse charges accepted)</p> <p>www.CIGNA.com/expatriates Customer Service</p> <p>With respect to eligibility to participate in the Plan: Senior International Benefits Manager The Dow Chemical Company Employee Development Center Midland, Michigan 48674 U.S.A. (989) 638-8757</p>
For Active Employees: Contact the HR Service Center	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (989) 638-8757
For Retirees:	The Dow Chemical Company Employee Development Center

Contact the Retiree HR Service Center	Midland, Michigan 48674 (800) 344-0661 or (989) 636-0977
To Apply for or to Appeal Denial of a Claim:	See <i>Claims Filing and Appeals Section</i> .
To Serve Legal Process File with:	Connecticut General Life Insurance Company 900 Cottage Grove Rd. Hartford, Connecticut 06152
COBRA	Towers Watson BenefitConnect COBRA Service Center PO Box 919051 San Diego, CA 92191-9863 (877) 292-6272
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	<p>The Dow Chemical Company and Participating Employers share the premium costs with Employees. Benefits are fully insured by Connecticut General Life Insurance Company (CGLIC).</p> <p>CGLIC is responsible for paying applicable benefits under the Plan, not The Dow Chemical Company or any Participating Employer.</p> <p>Assets of the Program, if any, can be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses can include, and are not limited to, consulting fees, actuarial fees, attorney fees, third-party administrator fees and other administrative expenses.</p>

<p>Payment of Unauthorized Benefits</p>	<p>If the Administrator determines that benefits in excess of the amount authorized under the Program were provided to a Participant, Dependent or other person:</p> <ul style="list-style-type: none">• 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 Administrator may require the Participant, Dependent or other person to reimburse the Program; and or <p>The 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 Administrator's error or by reason of false misleading, or inaccurate information furnished by the Participant or Dependent or any other person</p>
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Section 2. ELIGIBILITY

2.1 Active Employees

An Employee is eligible for coverage if he or she is an active, regular, Full-Time or Less-than-Full-Time Salaried Employee or Bargained-for Employee whose collective bargaining agreement provides for eligibility under the Plan, who either:

- Is designated by Dow as having Expatriate status and is on an international assignment under the Dow ; or
- Was covered under the Private Patient Plan on June 30, 2002.

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by the Participating Employer such as under the Company's Military Leave Policy, Family Leave Policy or Medical Leave Policy. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. Additionally, eligibility may continue for repatriation periods of up to one month if the employee goes on consecutive international assignments.

2.2 Retirees

One of the purposes of this Plan is to provide coverage to Retirees who (1) worked for a Dow entity that provides retiree medical coverage to its eligible retirees and would have otherwise been eligible for such retiree medical coverage had they not been requested by Dow to relocate internationally to perform services for Dow, or (2) worked for Dow in a country that provides government-sponsored retiree medical coverage (not including U.S. Medicare) and would have otherwise been eligible for such retiree medical coverage had they not been requested by Dow to relocate internationally to perform services for Dow. Such a Retiree is eligible for coverage under this Plan if he:

- Is a Retiree; or
- Was covered under the Private Patient Plan on June 30, 2002; AND
- Is not, at the time of Retirement, eligible for coverage under any other retiree medical program sponsored by Dow or entity 50% or more owned by Dow, or national health coverage provided by the government of the country from which he retires (including U.S. Medicare).

Retirees are not eligible for dental or vision coverage.

2.3 Dependents

Eligible Employees and Retirees can enroll their eligible Dependents. For active Employees, a Dependent may be either your Spouse or an eligible child. For Retirees, a Dependent may be either your Spouse of Record or an eligible child. If the law of the applicable country allows coverage for Domestic Partners, an active Employee may also enroll his or her Domestic Partner as a Dependent, and a Retiree may enroll his or her Domestic Partner of Record as a Dependent.

Dependent Child(ren)

Eligible Employees can enroll their eligible Dependents. A Dependent may be your Spouse or Domestic Partner or an eligible child. The Employee must be enrolled in order to enroll a Dependent Spouse/Domestic Partner or a Dependent child. Dependent children must meet the definition of “Dependent child”.

Definition of “Dependent child”:

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

- your birth or legally adopted child, or
- your stepchild (or your Domestic Partner’s child), or
- a child for whom you or your Spouse or 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” in a court of law means that the biological parents permanently do not have the:
 - authority to consent to the child’s Marriage or adoption;
 - authority to enlist the child in the armed forces of the US of any other country; or
 - right to the child’s services and earnings; or
 - 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 DP 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.

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.

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 Dow Chemical Company Insured Health Program's requirements. It gives a child the right to be covered under the Dow Program. 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 treat a divorce decree that orders the Employee to provide medical coverage for a specific child like 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 Dow Insured Health 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 Section 1 of this SPD, entitled "*ERISA Information*").

Dependent Child Exclusions

Your Dependent child will not be eligible for coverage under the Plan if he or she:

- **is covered as a Dependent under a Dow-sponsored medical plan of another Employee or Retiree of Dow** – all eligible child(ren) in a family must be covered by the same parent (exceptions can be made as necessary in stepchild situations); or
- **reaches age 26** - coverage ends on the child's 26th birthday. Children age 26 or older are not eligible. However, coverage may continue beyond age 26 if, **prior to** age 26, he or she is incapable of self-sustaining employment because of a physical or mental disability and is covered under the Plan on the day prior to reaching age 26. The child must be principally dependent upon you for support. Proof of the child's initial and continuing dependency and disability must be provided to the Plan prior to age 26 in order for coverage to continue. You must make any contribution required by the Plan to continue coverage for your child. Once the coverage is terminated, it cannot be reinstated. Contact the HR Service Center at (877) 623-8079 or (989) 638-8757 for active Employees or the Retiree Service Center at (800) 344-0661 or in Midland at (989) 636-0977 for Retirees for more information if this applies to you.

When your child no longer is eligible for Dependent coverage because of one of these events, you must complete and return a new enrollment form 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 an enrollment form available on the Dow Intranet or contact the HR Service Center. If you are a retiree, contact the Retiree Service Center to obtain an enrollment form. If you are an active Employee and you fail to complete and return the form within 90 days, 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. If you are a Retiree, the reduction in premium will be effective the date you contact the Retiree Service Center. In either case, the loss of coverage for your Dependent will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

For information about rights your child may have for continuation of coverage under the Program as provided by the federal COBRA law, see the Section 14 of this SPD entitled “*Ending Coverage.*”

Spousal and Domestic Partner Exclusions

Your Spouse or Domestic Partner (if you are an active Employee) or your Spouse of Record or Domestic Partner of Record (if you are a Retiree) is not eligible for coverage under the Plan if he/she is:

- eligible for coverage as a full-time employee or retiree under another employer's plan, but not enrolled for personal coverage in that plan (see the “*Working Spouse of Record Rule*” section for details); or
- enrolled for coverage as an Employee or Retiree under another Dow, or Dow-affiliated, medical 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's/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 a Dow Plan unless your Spouse/Domestic Partner has enrolled himself/herself in his/her employer's group health plan. If your Spouse's/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 Dow Plan.

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 or retirement benefits, the Dow Plan 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's/Domestic Partner's failure to enroll in his/her employer's group health plan was discovered by the Dow Medical Plan), 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 Dow Plan at the normal premium when the Plan learns that she/he 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 can not 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.

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 International Medical and Dental 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 retroactively cancelled. The Employee/Retiree is responsible for reimbursing the Plan for claims paid. Further, the Plan reserves the right to cancel the Employee/Retiree's own coverage if the Plan is not fully reimbursed.

There is not a requirement that your Dependent children must enroll in your Spouse's/Domestic Partner's plan to be eligible under the Dow Plan. If you decide to enroll your eligible Dependent child(ren) under a Dow Plan, and your Spouse/Domestic Partner also enrolls them under his/her employer's group health plan, the benefits for the child(ren) will be coordinated between the two health plans. When determining how, or the amount of Dow benefits that will be paid with respect to the child(ren), the Dow benefits will be coordinated using the birthday rule (see the *Coordination of Benefits* section), and will be coordinated according to the Spouse's/Domestic Partner's employer's plan most comparable to the Dow Plan you are enrolled in, regardless of the plan in which your Spouse/Domestic Partner is actually enrolled.

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.

Non-Dow Employed Spouse of Record or Domestic Partner of Record (Who Is a Dow Retiree)

If your Spouse of Record/Domestic Partner of Record is a Dow Retiree eligible for coverage under the Program because of his or her prior employment with Dow, and is also eligible for active medical coverage under another employer's plan, your Spouse of Record/Domestic Partner of Record is not required to enroll in that coverage in order to have coverage under the Dow Insured Health Program.

Dow Spouse of Record or Domestic Partner of Record Who Is an Active Employee

A Retiree (regardless of age) cannot carry a full-time active Employee as a Dependent. However, when you are both Retired, one of you may carry the other as a Dependent, providing coverage is through the Dow Insured Health Program, or one of Dow's self-insured retiree medical plans under The Dow Chemical Company Retiree Medical Care Program.

If your Spouse of Record or Domestic Partner of Record is covered under one of the active Employee medical programs sponsored by Dow, you may elect to be covered as a Dependent under his or her plan.

If You Are Medicare-Eligible

You are not eligible for coverage under this plan if you are eligible for Medicare.

Remarriage/New Domestic Partnership

If you remarry or enter into a new Domestic Partnership after Retirement, your new Spouse or Domestic Partner is NOT eligible for coverage under any Dow sponsored retiree medical program.

2.4 Eligibility Determinations

The applicable Claims Administrator determines eligibility. The applicable Claims Administrator is a fiduciary of the Program and has with respect to Eligibility Determinations, has the full discretion to interpret provisions of the SPD and the Plan Document and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants. If you would like the Claims Administrator to determine whether you are eligible for coverage, you can file a "Claim for an Eligibility Determination." See Section 11, *Claims Filing and Appeals*.

Section 3. ENROLLMENT

3.1 Levels of Participation

The levels of participation available are:

- Employee or Retiree Only
- Employee plus Spouse or Retiree plus Spouse of Record
- Employee plus Domestic Partner or Retiree plus Domestic Partner of Record
- Employee or Retiree plus Child(ren)
- Employee plus Spouse and Child(ren) or Retiree plus Spouse of Record and Child(ren)
- Employee plus Domestic Partner plus Child(ren) or Retiree plus Domestic Partner of Record plus Child(ren)

3.2 Enrolling as an Active Employee

You become eligible as an active employee when you go on expatriate assignment and elect this Plan. In some cases, you will have the option of remaining on your home plan, or moving to the host country plan. The U.S. Medical Plan cannot be used as the home or host country plan. Your International Relocation Partner will assist you with this process.

Beginning Employment

To enroll for Plan coverage upon hire, complete an enrollment form and return it to the U.S. Benefits Center within 90 days of beginning to work. If you are enrolling your Spouse/Domestic Partner and/or child(ren), you must provide proof of their eligibility within the 90-day period (Marriage certificate, Domestic Partnership statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate). If your enrollment form and proof of Dependent eligibility are received on or before 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 form is received if the proofs of Dependent eligibility are received by the U.S. Benefits Center within 90 days 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 retroactive to your date of hire, you may 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.

If you enrolled and submitted the required documentation after the 90-day period, your enrollment will be made retroactively effective to your date of hire. You must pay 102%

of the full cost to insure with post-tax dollars retroactive to your date of hire and for the remainder of that calendar year.

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.

Enrolling During Annual Enrollment- Applicable to Active Employees

Enrollment is typically held during the last quarter of the year. You can enroll for coverage, move to a home or host country plan where permitted 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 to add your Dependent, and submit it with proof of Dependent eligibility no later than the 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.

Dual Career Employees

If you and your Spouse or Domestic Partner are both Full-Time active, regular Dow Employees, or Less-than-Full-Time Employees, you each can enroll for medical coverage separately, or one of you may enroll and carry the other as a Dependent.

If you each enroll separately:

- your Dependent(s) can be covered by either one of you, but not both and
- your Deductibles and Out-of-Pocket Maximums will be calculated separately.

3.3 Enrolling at Retirement

Only in rare cases is the International Medical Plan available to Retirees. You are eligible for coverage under the International Medical Plan if you qualify as a Dow Retiree but are not eligible for a retiree medical plan in any country. (Example: If you are eligible for medical coverage as a retiree in Germany, but choose to live in the United States where the German plan will not cover you, you are not eligible for the International Medical Plan.) If you are enrolling your Spouse of Record/Domestic Partner of Record and/or child(ren), you must provide proof of their eligibility if requested by the Plan Administrator, i.e., marriage certificate, Domestic Partner statement, birth certificate, adoption papers or any other proof the Plan Administrator deems appropriate) within the timeframe requested by the Plan Administrator. FAILURE TO PROVIDE PROOF OF DEPENDENT ELIGIBILITY WHEN REQUESTED BY THE PLAN ADMINISTRATOR WILL RESULT IN NO COVERAGE FOR YOUR DEPENDENTS.

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

3.4 Special HIPAA Enrollment Provisions Under the Health Insurance Portability and Accountability Act (HIPAA)

If you decline enrollment in coverage under the Plan for yourself or your Dependents (including your Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record) 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 International Medical and Dental Plan coverage, you or your eligible Dependent must enroll in the Dow Plan within 90 days after the other coverage ends. However, if you or your Dependent declined Dow 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 cover yourself and your Dependent under the Plan if you enroll 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.

Section 4. MID-YEAR ELECTION CHANGES

4.1 Change in Status

For active Employees, if U.S. tax laws apply to you, you purchase your Employee, Spouse and Dependent coverage with pre-tax dollars through The Dow Chemical Company Flexible Spending Plan, a plan intended to qualify under Section 125 of the Internal Revenue Code as a “Cafeteria Plan.” Under U.S. 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, regardless of the post-tax treatment by IRS, to the extent that such administration does not jeopardize the tax-qualified status of the Program.

For Retirees, the Program administers changes in status events and the consistency rules the same way as for active Employees, except that you may drop a Dependent from coverage at any time.

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.

* Note that Retirees may not add a Spouse or Domestic Partner. Only Spouses of Record/Domestic Partners of Record may be eligible under the Plan. See definition of Spouse of Record/ Domestic Partner of Record. A divorce or annulment, or similar event with respect to a Domestic Partner is a change in status.

4.2 Consistency Rule

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

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

4.3 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, or QMCSO), requires a change in your medical plan election.
- **Entitlement to Medicare or Medicaid** – If you, your Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record, 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 or Spouse of Record/Domestic Partner of Record, 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 that 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** – 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.

On and after April 1, 2009, 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.

4.4 Documentation

Documentation is required to make an election change. Such documentation may include birth certificates, passports, Marriage certificates, Domestic Partner signed statements, evidence of loss of Spouse/Domestic Partner 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, and can result in retroactive cancellation of coverage. If this occurs, you may be required to reimburse the Plan Sponsor for any premiums already paid by the Plan Sponsor.

4.5 Deadline

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

If you know you will be adding a Dependent, as in the event of (with respect to Active Employees only) Marriage or Domestic Partnership, it is recommended that you pre-enroll your future Dependent, with coverage to begin when the proof of eligibility is received. Except for the birth or adoption of a child if the Plan Administrator receives your enrollment form 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 form 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.

Section 5. CONTRIBUTIONS

5.1 Active Employees

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 enrollment information that will be sent to you in the last quarter of each year. The amount you pay, through payroll deduction, is the difference between the total cost of CGLIC 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 form 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.

If you are on a leave of absence approved by the Participating Employer, and the leave of absence states that you are eligible under a medical plan sponsored by Dow, the Plan Administrator has the full discretion to make special administrative arrangements as are necessary, such as deferring Employee contributions on a temporary basis during the leave of absence and requiring you to pay double premiums when you return to work, or any other arrangements the Plan Administrator deems appropriate.

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

Excess 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) retroactive to the date you enrolled them. The Claims Administrator will seek reimbursement of any Claims paid retroactive to the date of enrollment. In addition, the Plan Administrator may require that you continue to pay premiums at the same enrollment level until you change your coverage during the next open enrollment, even

though coverage for your Dependent(s) was dropped retroactively effective to the date of ineligibility.

5.2 Leaves 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 any other means the Plan Administrator deems appropriate or necessary to collect the premiums.

If you go on an approved unpaid leave of absence under the Participating Employer's Family or Medical Leave Policy, then the Company will continue to maintain your Plan Benefits during the approved leave on the same terms and conditions as if you were still an active Employee. You must pay your share of the premium in one of the following ways. You must notify the Plan Administrator, in writing, at least two weeks before the beginning of the leave as to which method of payment you select; otherwise method #3 is the default method.

1. With post-tax dollars, by sending monthly payments to the Plan Administrator by the due date established by the Plan Administrator.
2. With pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation. (Only applicable if you are participating under S.125 US Internal Revenue rules)
3. The Employer may fund coverage during the leave and withhold "catch up" amounts upon your return.
4. Under another arrangement agreed upon between you and the Plan Administrator.

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

5.3 Changes of Election 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 Plan 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.

5.4 Retirees

You and Dow share the premium cost for Plan coverage and benefits according to the following guidelines:

- The premium is the cost associated with Plan coverage. The Company or Participating Employer pays part of this expense and you pay part of this expense. The portion that your Employer pays toward the premium is completely separate from benefits payable under the Plan.
- Failure to pay the required premiums will result in no coverage, or cancellation of coverage. If you are delinquent in paying premiums, you are required to reimburse the Plan for premiums you did not pay during the period in which you received coverage under the Plan. If you are delinquent in paying premiums, and you later want to enroll in the Plan, you must first reimburse the Plan for any unpaid premiums you owe before you will be permitted to enroll.
- Retiree costs may differ from Active Employee premiums.

Excess 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 will not refund the premiums you paid. The Plan may cancel coverage retroactively, and may seek repayment of any benefit claims paid for an ineligible dependent. In addition, the Plan Administrator may require that you continue to pay premiums at the same enrollment level until you change your coverage during the next open enrollment, even though coverage for your Dependent(s) was dropped retroactively effective to the date of ineligibility.

Section 6. MEDICAL COVERAGE

6.1 CIGNALinks

The information in this Section 6 may vary if you live in a geographic area where CIGNALinks is available. CIGNA Links is a program that allows CIGNA International to integrate expatriates in selected countries into a local network plan. In some of the CIGNALinks countries, the benefits may be slightly different than the standard CIGNA International Plan benefits. If you live in one of the countries identified by CIGNA as a CIGNALinks country, you will receive separate information on coverage. However, in no case will it be less than that indicated in this Section 6. Although the countries identified as CIGNALinks countries may change, they currently include the following countries: Australia, Hong Kong, United Kingdom, Spain, Singapore, Saudi Arabia, United Arab Emirates, Bahrain, Qatar and Kuwait.

6.2 Summary Schedule of Benefits

To receive Comprehensive Medical Benefits, you and your Dependent must pay a portion of the Covered Expenses. That portion is the Coinsurance.

Daily Limits shown below are Covered Expense allowances to which coinsurance is generally applied. The amounts that this Plan will pay may differ. Please refer to the section entitled "How Your Comprehensive Medical Plan Works" and to the Comprehensive Medical Benefits section on page 25 for a complete explanation of your benefits and any restrictions.

For You and Your Dependents	This Plan Will Pay:
<u>Deductible</u>	\$125 Individual / \$250 Family
Lifetime Maximum Benefit	Unlimited
Adult Routine Physical Examination Calendar Year Maximum	Unlimited
Child Preventive Care Services Calendar Year Maximums:	
• Children up to age 1	Unlimited
• Children ages 1 through 17	Unlimited
Chiropractic Treatment Calendar Year Maximum	20 visits
TMJ - Lifetime Maximum	\$500
Infertility Services Lifetime Maximum	\$25,000

Comprehensive Medical Benefits

For You and Your Dependents	This Plan Will Pay:
Hospital Bed and Board	
Daily Limit for a semiprivate room	The Reasonable and Customary Charge
Daily Limit for a private room	The Hospital's most common daily rate for a semiprivate room
Hospice Care Facility Daily Limit	The Reasonable and Customary Charge

How Your Comprehensive Medical Plan Works

This Plan pays 85% of Covered Expenses, and you or your Dependent pays 15% (except for Special Provisions and Conditions as noted below) of those Covered Expenses until you have paid \$4,000. Then this plan pays 100% of Covered Expenses. See conditions and provisions as noted in the Full Payment Area in the Comprehensive Medical Benefits section. Please note that deductibles do not apply to preventative benefits.

Special Provisions	Conditions	This Plan Will Pay
Adult Routine Physical Examinations	For Employees and Dependents age 18 and over	100%
Child Preventive Care Services	Children from birth through age 17	100%
Mammograms, Pap Tests and Prostate Specific Antigen (PSA) Tests	See "Covered Expenses"	100%
Lead Poisoning Screening Tests	For children under age 6	100%
Colorectal Cancer Screenings	See "Covered Expenses"	100%
Childhood Immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; Haemophilus influenza b; and hepatitis A	Children from birth through age 18	100%
Adult Routine Immunizations		100%
Travel Immunizations		100%
Home Health Care Benefits		85%

Special Provisions	Conditions	This Plan Will Pay
Skilled Nursing Facility Benefits		85%
Hospice Care Benefits		85%
Chiropractic Treatment		85%
TMJ Treatment		85%
Mental Illness, Alcoholism or Drug Abuse Benefits	In-Hospital	85%
Mental Illness, Alcoholism or Drug Abuse Benefits	Out-of-Hospital	85%
Infertility Services		50%
Benefit for Hospital charges during any inpatient admission in the United States	Without approval of Review Organization	50% of the amount otherwise payable
All Other Covered Expenses		85%
Prescription Drug Benefits Participating Retail Pharmacy Non-Participating Retail Pharmacy Participating Mail-Order Pharmacy	Applies to prescriptions obtained inside the United States only 85%	
Prenatal Care		85%

6.3 How the Plan Works

Under the Medical Plan, you choose the medical providers you wish to see. You must file your own claims for reimbursement.

The Plan pays most of the reasonable and customary charges you incur; you pay the remainder. (This is called Coinsurance.) You should note that some annual or lifetime benefit limits do apply.

6.4 Covered Expenses

Comprehensive Medical Benefits

Full Payment Area

When a person has incurred \$4,000 of Covered Expenses in a calendar year for which no payment is provided because of the coinsurance factor, benefits for him for Covered Expenses incurred during the rest of that calendar year will be payable at the rate of 100%

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Covered Expenses of \$8,000 in a calendar year for which no payment is provided because of the coinsurance factor, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred for or in connection with mental Illness will stay the same and the out-of-pocket expense resulting from the treatment of mental Illness will not apply toward the out-of-pocket limitation. Additionally, any penalties resulting from failure to co-employment with the PAC/CSR Requirements shown in the schedule will not apply toward the out-of-pocket limitation.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he/she becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses, to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness.

Medical Expenses

- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration;
- Charges made for diabetic education for insulin and non-insulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions at a facility approved by the American Diabetes Association, by a Physician or member of his office staff, podiatrist, or a certified or registered healthcare professional with recent education in diabetes management.
- Charges made for the following equipment and supplies for the treatment of diabetes, if recommended in writing or prescribed by a Physician: insulin pumps; blood glucose meters and strips; urine testing strips; insulin; syringes; lancets; alcohol swabs and pharmacological agents for controlling blood sugar.
- Charges made by a Nurse for professional nursing service.

Hospital Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital's most common daily rate for a semi-private room.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made (while a person is Confined in a Hospital) for drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins (other than prenatal vitamins) and fluoride.
- Charges made by a Free-standing Surgical Facility, on its own behalf, for medical care and treatment.

Preventive Care

- Charges made for adult routine immunizations.
- Charges made for travel immunizations.
- Charges made for or in connection with annual Papanicolaou (Pap) screening test.
- Charges made for or in connection with routine physical examinations for Employees and Dependents age 18 and over, including a chest x-ray, urinalysis, blood tests, and an EKG, not to exceed the Adult Routine Physical Examination Calendar Year Maximum shown in the *Summary Schedule of Benefits* in Section 6.1 of this SPD. Charges for eye and ear examinations for corrective lenses and hearing apparatus are not considered Covered Expenses under this benefit.
- Charges made for or in connection with an annual prostate cancer screening, commonly known as a prostate specific antigen (PSA) test for males age 50 or older.
- Charges made for or in connection with mammograms including; (a) a baseline mammogram for asymptomatic women at least age 35; (b) a mammogram every one or two years for asymptomatic women age 40-49, but no sooner than two years after a woman's baseline mammogram; (c) an annual mammogram for women age 50 and over; and (d) a mammogram, anytime, regardless of the woman's age, when prescribed by a Physician;
- Charges for children from birth through age 18 for immunization against: (a) diphtheria; (b) hepatitis B; (c) measles; (d) mumps; (e) pertussis; (f) polio; (g) rubella; (h) tetanus; (i) varicella; (j) Haemophilus influenza b; and (k) hepatitis A.
- Charges made for or in connection with one baseline lead poisoning screening test for children at or around 12 months of age. Also, for children under the age of 6 who are considered to be at high risk (in accordance with guidelines set by the Division of Public Health) coverage will include lead poisoning screening and diagnostic evaluation.
- Charges made for colorectal cancer screening as follows:
 - For persons 50 years of age or older: screening with annual fecal occult blood tests (three specimens), flexible sigmoidoscopy every five years, colonoscopy every ten years, double contrast barium enema every five years, or any combination of the most reliable, medically recognized screening tests available as may be determined by the Secretary of Health and Social Services of Delaware.
 - For persons who are deemed at high risk of colon cancer because of: (a) family history of familial adenomatous polyposis; (b) family history of hereditary non-polyposis colon cancer; (c) chronic inflammatory bowel disease; (d) family history of breast, ovarian, endometrial, colon cancer, or polyps; (e) a background (ethnic or lifestyle) such that the health care provider treating the insured believes that he or she is at elevated risk; (f) screening by colonoscopy, barium enema, or any combination of the most reliable, medically recognized screening tests available as determined by the Secretary of Health and Social Services of Delaware are covered at a frequency determined by the Physician.

In addition, Covered Expenses will include expenses incurred for a Dependent child who is age 17 or less for charges made for Child Preventive Care Services consisting of the

following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a health history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;
- excluding any charges for:
 - services which exceed the Child Preventive Care Services Calendar Year Maximums shown in the *Summary Schedule of Benefits* in Section 6.1 of this SPD;
 - services for which benefits are otherwise provided under this Comprehensive Medical Benefits section;
 - services for which benefits are not payable according to the Expenses Not Covered section.
- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:
 - part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;
 - part-time or intermittent services of a Home Health Aide;
 - physical, occupational, or speech therapy;
 - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for:

- more than 120 home health care visits during a calendar year; (To determine the benefits payable, each 2 hours of Home Health Aide services by an employee of a Home Health Care Agency will be considered as one home health care visit. The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (i.e., max of 8 visits per day). Home health care visits include outpatient private duty nursing when medically necessary.
- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

Alternative Care Settings

- Charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement in a private room, Covered Expenses will not include that portion which is more than the Skilled

Nursing Facility's most common rate for a semiprivate room, or charges for more than 60 days of confinement in a Skilled Nursing Facility during any one calendar year.

- Charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in the *Summary Schedule of Benefits* in Section 6.1 of this SPD;
 - by a Hospice Facility for services provided on an outpatient basis;
 - by a Physician for professional services;
 - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
 - for pain relief treatment, including drugs, medicines and medical supplies;
 - by a Home Health Care Agency for:
 - ◆ part-time or intermittent nursing care by or under the supervision of a Nurse;
 - ◆ part-time or intermittent services of a Home Health Aide;
 - ◆ physical, occupational and speech therapy;
 - ◆ medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

Mental Illness/Substance Abuse

- Charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of Mental Illness provided on an outpatient basis.
- Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- Charges made by a Physician or a Psychologist for professional services.

- Charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses.

Other Covered Services

- Charges for rental or, at CGLIC's option, purchase of Durable Medical Equipment;
- Charges for therapy provided by a licensed physical, occupational or speech therapist;
- Charges for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease.
- Charges for prosthetic appliances; prostheses following a mastectomy; and dressings;
- Charges made (outside of the United States) for drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins (other than prenatal vitamins), and fluoride.
- Charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CGLIC before you incur any such costs.
- Charges made for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA) and for outpatient contraceptive services including consultations, examinations, procedures and medical services related to the use of contraceptive methods to prevent unplanned pregnancy. Charges made for the insertion and removal and medically necessary examination associated with the use of such FDA approved contraceptive drug or device are also included.
- Charges made by a Physician for Infertility Services, including services related to the treatment of Infertility once a condition of Infertility has been diagnosed. Also included are services for further diagnosis to determine the cause of Infertility.

Infertility Services include, but are not limited to: Infertility drugs which are administered or provided by the Physician, surgeries and other therapeutic procedures, laboratory tests, sperm washing or preparation, diagnostic evaluations, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and the services of an embryologist.

This benefit includes diagnosis and treatment of both male and female Infertility. However, the following are specifically excluded Infertility services:

- a reversal of voluntary sterilization;
- Infertility services when the Infertility is caused by or related to voluntary sterilization;
- donor charges and services, and
- any experimental or investigational Infertility procedures or therapies.

Covered Expenses for Infertility Services will be limited to \$25,000 per person, per lifetime.

6.5 Prescription Drugs

If you or your Dependent purchases Covered Prescription Drugs from a Participating Retail Pharmacy, you pay only 15% of the cost at the time of purchase. You do not need to file a claim form.

If you or your Dependent purchases Covered Prescription Drugs from a non-Participating Retail Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form in order to be reimbursed for the amount payable by the plan.

You may obtain the required claim form from your Benefit Plan Administrator. All claim forms should be completed by you.

Covered Prescription Drugs

The term Covered Prescription Drugs means:

- a Prescription Legend Drug for which a written prescription is required;
- oral or injectable insulin dispensed only upon the written prescription of a Physician;
- insulin needles and syringes;
- tretinoin for individuals through age 35;
- a compound medication of which at least one ingredient is a Prescription Legend Drug;
- any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician;
- oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
- prenatal vitamins, upon written prescription;
- glucose test strips.

Limitations

No payment will be made for expenses incurred for:

- nonlegend drugs, other than those specified under "Covered Prescription Drugs;"
- drugs for which payment is unlawful where the person resides when expenses are incurred;
- charges which the person is not legally required to pay;
- charges which would not have been made if the person were not covered by these benefits;
- experimental drugs or for drugs labeled: "Caution - limited by federal law to investigational use;"

- drugs which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CGLIC or RxPRIME;
- drugs obtained from a non-Participating Mail-Order Pharmacy;
- any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician's order;
- indications not approved by the Food and Drug Administration, except as specified under "Covered Prescription Drugs;"
- immunization agents, biological sera, blood or blood plasma;
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, excluding insulin syringes;
- drugs for cosmetic purposes;
- tretinoin for individuals age 36 and over;
- administration of any drug;
- medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
- growth hormones and anabolic steroids;
- nutritional or dietary supplements, antiobesity drugs or anorexients;
- prescription vitamins other than prenatal vitamins, upon written prescription;
- oral infertility drugs;
- smoking cessation products.

6.6 Exclusions

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless:
 - a person receives an Injury which results in bodily damage requiring the surgery; or
 - it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or
 - it is performed to correct a congenital abnormality on one of your Dependents who has not reached skeletal maturity; or
 - it qualifies as reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
 - charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth;
 - charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or
 - charges made by the outpatient department of a Hospital in connection with surgery.
- for charges made by a Physician for Chiropractic treatment, while not Confined in a Hospital, which exceed the Calendar Year Maximum of 20 visits per person.
- for charges made by a Physician for the treatment of Temporomandibular Joint Disorder (TMJ), which exceed the lifetime limit of \$500 per person.
- for which benefits are not payable according to the "*General Exclusions & Limitations*" section.

6.7 PAC/CSR and Case Management

PAC/CSR

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CGLIC has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this Plan will not include the first \$300 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

The amount otherwise payable under this plan for the Hospital charges listed below will be reduced by 50% for:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician and CGLIC.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians qualified in treatment of the condition, including Mental Illness, alcohol or drug abuse.

This provision is applicable to:

- you or your Dependents residing in the United States.
- you or your Dependents who reside outside the United States but who elect to receive medical treatment in the United States.

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital

or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis. Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the CIGNA International Service Center directly at 1-302-797-3100 (outside the U.S. and Canada, call collect) or 1-800-441-2668 (inside the U.S. and Canada). In addition, your Employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. Intracorp assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary—no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of an extended Hospital convalescence.) You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a Hospital bed and other Durable Medical Equipment for the home.)
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide

assistance in obtaining needed medical resources and ongoing family support in a time of need.

6.8 Coverages Required by U.S. Federal Laws

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 (WHCRA)

The 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;
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs; and
- prosthetics and treatment of physical complications at all stages of the mastectomy including lymphedemas.

If you have any questions about your benefits under this Plan, please call the number on your ID card or contact your Employer.

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.

Section 7. DENTAL COVERAGE

7.1 Summary Schedule of Benefits

<p>Class I Preventive Care</p>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Plan pays 100% There is no Deductible </div>			<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Up to \$1,500 per person per Calendar Year, combined </div>
<p>Class II Basic Restorative</p>	Then	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Plan pays 80% </div>		
<p>Class III Major Restorative</p>	Then	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Plan pays 50% </div>		
<p>Class IV Orthodontia</p>		<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Plan pays 50% </div>		
<p>Class V Dental Implant Services</p>	Then	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Plan pays 80% There is no Deductible </div>		
			<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Up to \$1,500 per person, lifetime </div>	
Lifetime maximum is \$10,000				

(Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.)

7.2 How the Plan Works

The Dental Plan provides comprehensive coverage for you and your eligible Dependents and encourages preventive care such as cleanings and regular check-ups.

The Plan covers all or a portion of your expenses for most types of Dental care. Before the Plan will pay benefits, you must meet an annual \$50 deductible. (However, the deductible will not apply to preventive care services). To help limit your out-of-pocket expenses, the Plan imposes a **family** annual deductible of \$150. No individual can contribute more than his or her individual deductible towards the family deductible.

7.3 Covered Expenses

If you or any one of your Dependents incurs Covered Expenses, the Plan will:

- deduct any Dental Deductible that applies from the Covered Expenses first incurred in a calendar year for a person and
- pay for the other Covered Expenses incurred in that calendar year up to the Maximum Covered Expense determined from the Dental Services Schedule for each Dental Service subject to the Alternate Benefit Provision.

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed on pages 37-38.

Covered Expenses will include only those expenses incurred for such charges when the Dental Service:

- is performed by or under the direction of a Dentist,
- is essential for the necessary care of the teeth and
- starts and is completed while the person is insured.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. CGLIC may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to CGLIC.

CGLIC will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

A temporary Dental Service is included in the allowance for the final Dental Service and is not a separate Dental Service.

DENTAL SERVICES SCHEDULE

CLASS I SERVICES - Diagnostic and Preventive

This Plan will pay up to the Reasonable and Customary Charge for:

- Clinical oral examination - Only two per person per calendar year.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- X-rays - Complete series - Only one per person, including Panoramic film, in any three calendar years.
- Bitewing X-rays - Only two charges per person per calendar year.
- Panoramic (Panorex) X-ray - Only one per person in any three calendar years.
- Prophylaxis (Cleaning) - Only two per person per calendar year.
- Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.
- Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 19 years old. Only one per person per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only one treatment per tooth in any three calendar years.
- Space Maintainers, fixed unilateral - Limited to nonorthodontic treatment.

CLASS II SERVICES - Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

The Plan will pay up to 80% of the Reasonable and Customary Charge for:

- Amalgam filling - primary (baby) teeth, one surface
- Amalgam filling - permanent teeth, one surface
- Composite/resin filling, one surface
- Root canal therapy - any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
- Osseous surgery - flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service. If more than one periodontal surgical service is performed per quadrant, only the one with the largest Maximum Covered Expense is a Dental Service.
- Periodontal scaling and root planing - entire mouth
- Adjustments - Complete denture (any adjustment of or repair to a denture within six months of its installation is not a separate Dental Service).
- Recement bridge
- Simple extractions

- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- Removal of impacted tooth, soft tissue
- Removal of impacted tooth, partially bony
- Removal of impacted tooth, completely bony

DENTAL SERVICES SCHEDULE

- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.
- General Anesthesia - Paid as a separate benefit only when medically or dentally necessary, as determined by CGLIC, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I.V. Sedation - Paid as a separate benefit only when medically or dentally necessary, as determined by CGLIC, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

CLASS III SERVICES - Major Restorations, Dentures and Bridgework

The Plan will pay up to 50% of the Reasonable and Customary Charge for:

- Crowns
 - Porcelain fused to high noble metal
 - Full cast, high noble metal
 - Three-fourths cast, metallic
- Fixed or removable appliances
 - Complete (full) dentures, upper or lower
- Partial dentures
 - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
 - Upper, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- Bridge pontics - cast high noble metal
- Bridge pontics - porcelain fused to high noble metal
- Bridge pontics - resin with high noble metal
- Abutment crowns - resin with high noble metal
- Abutment crowns - porcelain fused to high noble metal
- Abutment crowns - full cast high noble metal

High noble metal (gold) or crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

CLASS IV SERVICES – Orthodontics

The Plan will pay up to 50% of the Reasonable and Customary Charge for the following services:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance
- Active treatment per month after the first month
- Fixed or removable appliances - only one appliance per person
 - for tooth guidance
 - to control harmful habits

Each month of active treatment is a separate Dental Service.

Class V Services – Dental Implant Service

Deductible: zero

Coinsurance: 80%

Lifetime Maximum; \$10,000

A Dental Implant includes any type of surgical implant placed in the jawbone for the specific purpose of providing support for an attached dental prosthesis.

Surgical placement of implant body – (Any type dental implant). Coverage is limited to one within a 5-year period per implant site.

Abutment placement or substitution. Coverage is limited to one within a 5-year period per implant site.

Implant maintenance procedures, including removal of attached prosthesis, cleansing of prosthesis, repair of implant abutment and abutments, and reinsertion of prosthesis. Coverage is limited to 2 per calendar year.

Surgical removal of (failed) implant.

An implant supported connector bar and/or denture will be subject to the provisions of the contract for Class III Major Restorative Services.

Cleaning of teeth, including Implant supported crowns and/or fixed bridges, will be subject to the provisions of the contract for Class I Diagnostic and Preventive Service, provided there is no removal or reinsertion of implant.

Implants

An implant is a device surgically placed in the jawbone which is used specifically to provide support for an attached dental prosthesis. The procedure of placing the implant includes the materials and components associated with the surgical implantation.

Prosthetic devices attached to the implant include the crown, abutment crown connector bar, and fixed bridge.

Covered Expenses for implants will include:

- surgical placement of dental implant;
- abutment, repair, maintenance, cleansing, removal, and reinsertion of implant and/or abutment.

Alternate Benefit Provision

When more than one Dental Service could provide suitable treatment based on common dental standards, CGLIC will determine the Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care.

You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed Covered Expenses. For this reason, CGLIC strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your Dentist know in advance what the benefit plan will cover before any treatment begins.

Predetermination of Benefits

The term “Predetermination of Benefits” means a review by CGLIC of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to CGLIC before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CGLIC.

The expenses that will be included as Covered Expenses will be determined by CGLIC and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CGLIC will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

7.4. Exclusions & Limitations

Limitations

Missing Teeth Limit

The amount payable is 50% of the amount otherwise payable for first replacement of teeth that are missing when a person becomes insured for these benefits. After a person has been continuously insured for these benefits for 24 months, this limit will no longer apply.

Late Entrant Limit

No benefits are payable for Class III or Class IV Dental Services if you or your Dependent is a Late Entrant for Dental Insurance. After a person has been continuously insured for these benefits for 12 months, this limit will no longer apply.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics for a Dependent Child less than 19 years of age during his or her lifetime will not be more than \$1,500.

Maximum Benefit Provision

The total amount payable for all expenses incurred for other than Orthodontics for a person in a calendar year will not be more than \$1,500.

Expenses Not Covered

The Plan will not cover, and no payment will be made for, expenses incurred for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;

- orthodontic services or supplies for any person other than a Dependent child less than 19 years of age;
- porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semi-precision attachments; or splinting;
- a surgical implant of any type including any prosthetic device attached to it;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- a portion of charges for a Dental Service that exceeds the Maximum Covered Expense for that service;
- services that are deemed to be medical services;
- services and supplies received from a hospital; and
- services for which benefits are not payable according to the "*General Exclusions and Limitations*" section.

In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under:

- this plan; and any
- medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Section 8. VISION COVERAGE

8.1 Summary Schedule of Benefits

Vision Benefits

For You and Your Dependents	This Plan Will Pay:
Examinations	
Per Examination, one per 24-month period	\$30
Lenses	
Per pair, one pair per 24-month period	
<ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular • Contact Lenses 	<ul style="list-style-type: none"> \$25 \$50 \$70 \$90 \$120
Frames	
Per pair, one pair per 24-month period	\$25

8.2 How the Plan Works

The Vision Plan provides benefits for exams, glasses and/or contact lenses for you and your covered Dependents.

8.3 Covered Expenses

For You And Your Dependents

If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for:

- an eye examination by an Optometrist or an Ophthalmologist;
- lenses to correct vision; or
- eyeglass frames;

CGLIC will pay you for such expenses up to the amount shown above.

No payment will be made for more than one examination and one pair of lenses during a 24-month period; or more than one pair of frames during a 24-month period for any one person.

8.4 Limitations

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- sunglasses, whether or not prescribed;
- replacement of lenses unless an examination shows that, using the existing prescription, a visual defect equal to at least one-half of one diopter in strength exists or a change of at least 10% in axis for astigmatism is required;
- care not listed on page 42;
- tinted lenses prescribed by the examiner when over Rose Tints No. 1 or No. 2; or
- charges for the excess cost of lenses over 65 millimeters in diameter.

Other Limitations are shown in the "*General Exclusions and Limitations*" section.

In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Section 9. GENERAL EXCLUSIONS AND LIMITATIONS

Medical, Dental and Vision Care Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in the *Summary Schedule of Benefits* in Section 6.1 of this SPD;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
- for charges for Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
- for claim payments that are illegal under applicable law.
- to the extent of the exclusions imposed by any certification requirement shown in the *Summary Schedule of Benefits* in Section 6.1 of this SPD;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge

means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);

- for charges made for or in connection with routine refractions under your medical plan, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CGLIC;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law or
- an uninsured motorist insurance law.

CGLIC will take into account any adjustment option chosen under such part by you or any one of your Dependents.

Section 10. IF YOU ARE ELIGIBLE FOR MEDICARE

If you are:

- a former Employee (including Retiree) who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- a former Employee's (including a Retiree) Dependent, or a former Dependent Spouse/Domestic Partner or Spouse of Record/Domestic Partner of Record, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- an Employee or Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

your coverage will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this Plan will be reduced so that the total amount payable by Medicare and by CGLIC will be no more than 100% of the expenses incurred.

CGLIC will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he/she would receive if he/she had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he/she would receive if he/she were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he/she would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

Section 11. CLAIMS FILING AND APPEALS

11.1 Introduction

A “Claim” is a written request by a claimant for

1. a plan benefit or
2. an Eligibility Determination that contains, at a minimum, the information described below, and is addressed and delivered to the Initial Claims Reviewer.

A Claim for a Plan benefit is a written request that CIGNA pay for benefits covered the Plan. A Claim for an Eligibility Determination is a written request for a determination as to whether a claimant is eligible to enroll in the Plan.

The Plan 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.

For a Claim for an Eligibility Determination, the initial determination is made by the Initial Claims Reviewer. The Initial Claims Reviewer is the Senior International Benefits Manager for The Dow Chemical Company. The Associate Director North America Benefits is the Appeal Administrator. If you appeal, the appellate decision is made by the Associate Director North America Benefits for The Dow Chemical Company.

The applicable Administrator for determinations of whether a Claim for Plan Benefits is payable under the provisions of the Plan for both the initial determination and (if you appeal) the appellate determination is CGLIC.

11.2 Authorized Representatives

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 (If notarization is not available, then such writing must be sufficiently certified in accordance with local rules and procedures.). 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.

11.3 Authority of Claims Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete and final discretion to interpret the provisions of the Program and to make findings of fact in order to carry out their respective decision-making responsibilities. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants. 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 such Administrator under Section 502 of the U.S. Employee Retirement Income Security Act (ERISA) in U.S. 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.

11.4 Eligibility Determination Claims (i.e., are you eligible to Participate in the Plan?)

Submitting a Claim

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

- the name of the 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:

Senior International Benefits Manager
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674

Attention: Initial Claims Reviewer for International Medical and Dental Program of 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 before the initial 90-day period expires, 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.

11.5 Appealing a Denial of Eligibility to Participate in the Plan

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 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 North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, Michigan 48674

Attention: Appeals Administrator of the International Medical and Dental Plan of The Dow Chemical Company Insured Health Program (Appeal of Eligibility Determination)

You can submit any additional information to the Global Director of 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 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 North America Benefits receives your written request to appeal the initial determination, the Associate Director 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 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 North America Benefits is not a subordinate who reports to the person who made the initial decision to deny the Claim. The Associate Director 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 North America Benefits can have up to an additional 60 days to provide written notification of the final decision. If the Associate Director 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 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 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 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 North America Benefits receives your response, regardless of the adequacy of your response.

If the Associate Director North America Benefits denies the Claim or appeal, the Associate Director 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.

11.6 Claims for Benefits (i.e., obtaining payment for medical services)

Submitting a Claim

You must file a Claim for Benefits with CGLIC. You must follow CGLIC’s claims procedures, as described below. You can request a copy of the claims procedures applicable to CGLIC by calling toll free at 1/800-441-2668 (If dialing internationally, use that country’s AT&T access code), or call 302/797-3100 (reverse charges accepted). Or, send an email to the CGLIC Customer Service Representatives, Or contact CIGNA International Customer Service at 1-800-441-2668 or 1-302-797-3100 (reverse charges accepted) for forms and/or authorization to CIGNA secure mail.

You can download a claims form from www.CGLIC.com/expatriates.

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be mailed directly to:

CIGNA International Service Center
P.O. Box 15050
Wilmington, DE 19850 U.S.A.

If remitting via a courier service use the following street address:

590 Naamans Road
Claymont, DE 19703 U.S.A.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to the CIGNA International Service Center.

Doctor's Bills and Other Medical, Dental or Vision Expenses

The first Medical, Dental or Vision Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

Claim Reminders:

- Be sure to use your policy number when you file CIGNA International claim forms, or when you call the CIGNA International Service Center.
- Your policy number is 02002A.
- Prompt filing of any required claim forms results in faster payment of your claims.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison

11.7 Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CGLIC within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CGLIC receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CGLIC receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CGLIC within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CGLIC, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

11.8 Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CGLIC. No action will be brought at all unless brought within three years after the time within which proof of loss is required.

11.9 Payment of Benefits

To Whom Payable

All Medical, Dental and Vision Benefits are payable to you. However, at the option of CGLIC and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CGLIC, is not able to give a valid receipt for any payment due him, such payment will be made to his or her legal guardian. If no request for payment has been made by his or her legal guardian, CGLIC may, at its option, make payment to the person or institution appearing to have assumed his or her custody and support.

If you die while any of these benefits remain unpaid, CGLIC may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters or to the executors or administrators of your estate.

Payment as described above will release CGLIC from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CGLIC when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CGLIC, CGLIC will have the right at any time to:

- recover that overpayment from the person to whom or on whose behalf it was made; or
- offset the amount of that overpayment from a future claim payment.

11.10 Appealing a Denied Claim for Benefits

The following complies with state and federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

If you have a concern regarding a person, a service, the quality of care or contractual benefits, you can call the CIGNA International Service Center at 1-800-441-2668 (inside the United States and Canada) or 1-302-797-3100 (outside the United States and Canada, call collect).

CGLIC will make every attempt to resolve the matter on your initial contact. However, if additional time is needed to investigate your concern, CGLIC will notify you within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CGLIC has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Please submit your written appeal to:

CIGNA International
attn: Appeal Department
P.O. Box 15050
Wilmington, DE 19850-5050

You may also contact the CIGNA International Service Center directly to initiate the appeal process.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, CGLIC will respond in writing with a decision within five working days after it receives an appeal for a required pre-service or concurrent care coverage determination (decision).

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CGLIC's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CGLIC will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist

reviewer in the same or similar specialty as the care under consideration, as determined by CGLIC's Physician or Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals CGLIC will acknowledge in writing that it has received your request and will schedule a Committee review. For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, CGLIC will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request a 30-day extension during the Committee review period due to your necessity or convenience. Your request for this extension must be made within five calendar days from receipt of the appeals acknowledgment letter.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CGLIC's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, CGLIC will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CGLIC's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CGLIC or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CGLIC will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CGLIC. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 60 days of your receipt of CGLIC's level two appeal review denial. CGLIC will then forward the file to the Department of Health which assigns an Independent Review Organization under the Department's Independent Health Care Appeals Program.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to your condition, as determined by CGLIC's Physician or Dentist reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CGLIC.

Appeal to the State of Delaware

You have the right to contact the Department of Health and Social Services to have the appeal reviewed for the appropriate inclusion in the independent review, if your benefit excludes you from the independent review process. The request must be in writing. The Department of Health may be contacted at the following address and telephone number:

Department of Health and Social Services
2055 Limestone Road, Suite 200
Wilmington, DE 19080

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined;
- a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA Section 502(a);
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CGLIC until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Section 12. COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one medical plan, benefits payable from all such plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

- the benefits that would be payable from this Plan, in the absence of coordination; and
- the benefits that would be payable from all other plans without Coordination of Benefits provisions in those plans; would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

- those reduced benefits; and
- all the benefits payable for those Allowable Expenses from all other plans; will not exceed the total of such Allowable Expenses. Benefits payable from all other plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another plan will be ignored when the benefits of this Plan (CGLIC) are determined if:

- the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and
- the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

The Plan reserves the right to release to or obtain from any other insurance company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other plans, this Plan will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. This Plan will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by this Plan at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as it may determine.

12.1 Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by another plan that covers the person for whom claim is made. When the benefits from another plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except only if the hospitalization is outside the U.S. and a semi-private room equivalent is not available.

12.2 Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan .

12.3 Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

1. The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
2. The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that:
 - (a) if the other Plan does not have this rule, its alternate rule will govern; and
 - (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
3. If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:
 - (a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.
 - (b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.
4. When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be

determined before a Plan which has covered the person for the shorter period of time; except that:

- (a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.
- (b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

Section 13. CONDITIONAL CLAIM/ SUBROGATION

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CGLIC, another party may be liable:

- CGLIC shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CGLIC's subrogation rights.
- Alternatively, CGLIC may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CGLIC the lesser of:
 - the amount actually paid for such Covered Expenses by CGLIC; or
 - the amount you actually receive from the third party for such Covered Expenses;

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

Section 14. ENDING COVERAGE

14.1 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, contact the Retiree Service Center at (800) 344-0661 or in Midland at (989) 636-0977. You may qualify for a reduction in your monthly premium. Complete and return a new enrollment form or call the HR Service Center within 90 days of the loss of eligibility. If you qualify for a reduction in premium, the premium will be reduced effective the date you contact the Retiree Service Center.

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.

14.2 Your Right to Continuation Coverage Under COBRA

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 Plan when you would otherwise lose your group health coverage because of a qualifying event.

Although COBRA does not apply to Domestic Partners, the Program will provide Domestic Partners the same protection it provides Spouses and Spouses of Record 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 Dow Chemical Company. The Plan Administrator can be contacted:

U.S. Benefits Center
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Active Employees: 1(877) 623-8079 or (989) 638-8757
Retired Employees: 1(800) 344-0661 or (989)636-0977

COBRA continuation coverage for the Program is administered by Ceridian COBRA Continuation Services (formerly known as “CobraServ”). Ceridian can be contacted:

Towers Watson
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 or you are the Spouse of Record of a Retiree, 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the plan sponsor, and that bankruptcy results in the loss of coverage of a Retiree covered under the Program sponsored by the Plan Sponsor, the Retiree is a qualified beneficiary with respect to the bankruptcy. The Retiree's Spouse of Record, Surviving Spouse of Record, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy (only

applicable to the Programs offering coverage to Retirees), or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Ceridian 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 if you are an active employee) or calling the Retiree Service Center (if you are a Retiree). 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**
- **Dependent Qualifying Event Letter**

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 either the Dow Intranet, 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 and covered Retirees 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 the Ceridian election form and following the procedures specified on the election form. Your written notice must be provided to Ceridian 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 or Retiree, enrollment of the Employee or Retiree 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 Ceridian 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 Ceridian and a copy of the written determination of disability

from the Social Security Administration to Ceridian 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 Ceridian 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 Ceridian 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 (of an active Employee), Spouse of Record (of a Retiree) 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 the Ceridian. This extension may be available to the Spouse (of an active employee) and Spouse of Record (of a Retiree) and Dependent children if the former Employee or Retiree dies, enrolls in Medicare (Part A, Part B, or both) and this causes a loss of coverage under the Program, or gets divorced. The extension may also be available to a Dependent child when that child stops being eligible under the Program as a Dependent child. The extension is only available if the event would have caused the Spouse (of an active Employee), Spouse of Record (of a Retiree) 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 Ceridian 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 Ceridian 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. 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 Ceridian. 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 Ceridian 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 invoice from Ceridian. 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. Ceridian will send you periodic notices of payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

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 or Retiree 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 or Retiree 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 or Retiree. 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 or covered Retiree 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 or covered Retiree's period of employment with the employer is entitled to the same rights under COBRA as a Dependent child of the covered Employee or covered Retiree, 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 Ceridian. 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/ebsa.

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.

14.3 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 (e.g., Employee Only, Family, Employee plus Spouse of Record, etc.). 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 Plan coverage ceases by writing to the Retiree Service Center or 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. 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 Dependents.

Section 15. YOUR RIGHTS

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites or union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan 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 documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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 health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Preexisting coverage exclusions will not apply to any member under the age of 19.

15.1 Prudent Action by Plan Fiduciaries

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 Plan, 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. 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 benefit or exercising your rights under ERISA.

15.2 Enforcement of 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 one 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 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 state or federal court. In addition, if you disagree with the Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 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.

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15.3 Right to Privacy

You are entitled to certain privacy rights. These rights are described in Notice of Privacy Practices Appendix to this SPD. Additional privacy rights are described in the Plan Document for The Dow Chemical Company Insured Health Program.

Section 16. OTHER IMPORTANT INFORMATION

16.1 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 11.3 for information about the Claims Administrator's discretion.

16.2 No Guarantee

Welfare benefits, such as the International Medical and Dental Plan of The Dow Chemical Company Insured Health Program, are not required to be guaranteed by a government agency.

16.3 Amendment, Modification, or Termination of Plan

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

16.4 Disposition of Plan Assets if the Program Is Terminated

The Company may terminate the Plan or 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 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.

16.5 Fraud

Any Participant who intentionally misrepresents information to the Plan or knowingly misinforms, deceives or misleads the 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 Plan for Claims paid by CGLIC. The Plan or CGLIC may choose to pursue civil and/or criminal action. The Plan Administrator may determine that such Participant and the Employee and all other Dependents are no longer eligible for coverage under the Plan based upon the Participant's actions. In addition if a person has intentionally misrepresented information to any other benefit program sponsored by Dow or Union Carbide ("Other Benefit Program"), the Plan Administrator may determine that such person and the Employee and all other Dependents are not eligible for coverage under the Program.

16.6 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.

16.7 Assistance with Your Questions

If you have any questions about the 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 CGLIC at 1-80-441-2668 (If dealing internationally, use that country's AT&T access code), or call 1-302-797-3100). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration at (800) 998-7542.

16.8 Funding

The Dow Chemical Company and Participating Employers share the premium costs with Employees. Benefits are fully insured by Connecticut General Life Insurance Company (CGLIC).

CGLIC is responsible for paying applicable benefits under the Plan, not The Dow Chemical Company or any 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.

Section 17. DEFINITIONS

The following are some of the defined terms of the Dow Insured Health Program. Additional terms are defined in the Plan Document for the 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 Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Appeals Administrator

The Appeals Administrator with respect to reviewing an adverse Claim for Benefit is CGLIC. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the Associate Director North America Benefits for The Dow Chemical Company.

Bargained-for Employee

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

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is defined as: schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorder; panic disorder; anorexia nervosa; bulimia nervosa; schizo-affective disorder; and delusional disorder. The diagnostic criteria set out in the Diagnostic and Statistical Manual of Mental Disorders will be used to determine if a condition qualifies.

Certificate of Insurance

The insurance certificate issued by CGLIC. A copy of the Certificate of Insurance is inserted in the side pocket on the back cover of this SPD, or if you are accessing this SPD on the Dow Intranet, you may request a copy from CGLIC or the Plan Administrator by

making a written request to the address listed in the *ERISA Information* section of this SPD.

CGLIC

Connecticut General Life Insurance Company

Claim

A written request by a claimant for a benefit under the Plan or an Eligibility Determination that contains, at a minimum, the information described in Section 11 of this SPD entitled *Claims Filing & Appeals*.

Claim for Eligibility Determination

A Claim requesting a determination as to whether a claimant is eligible to enroll in the Plan. A “Claim for Eligibility Determination” does not include a request for determination of eligibility under the Plan’s COBRA provisions.

Claim for Plan Benefits

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

Claims Administrator

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

COBRA

The U.S. federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) that allows a member or Dependent to stay enrolled in the Plan for a limited time after coverage for that person would ordinarily cease.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Company

The Dow Chemical Company.

Covered Person or Participant or Member

An Employee, Retiree, Surviving Spouse/Domestic Partner (for active Employees), Surviving Spouse/Domestic Partner of Record (for Retirees), or a Dependent who is covered under the Plan.

Creditable Coverage

Coverage under The International Medical and Dental Plan of The Dow Chemical Company Insured Health Program, Medicare, Medicaid, or any other group health,

individual health or other health insurance coverage described in a U.S. regulation, 29 CFR s. 2590.701-4.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent Child

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

- your birth or legally adopted child, or
- your stepchild (or your Domestic Partner’s child), or
- a child for whom you or your Spouse or 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” in a court of law means that the biological parents permanently do not have the:
 - authority to consent to the child’s Marriage or adoption;
 - authority to enlist the child in the armed forces of the US of any other country; or
 - right to the child’s services and earnings; or
 - 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 Partner of Record

For Retirees who are eligible for coverage under the Program prior to January 1, 2003, "Domestic Partner of Record" means a person who was eligible for Domestic Partner benefits from The Dow Chemical Company Retiree Medical Care Program on December 31, 2002. In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to December 31, 2002.

For Retirees who become eligible for coverage under the Program on or after January 1, 2003, "Domestic Partner of Record" means a person who was eligible for Domestic Partner benefits from The Dow Chemical Company on the Employee's last day on the payroll. In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the date the Employee Retired.

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

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 in a state or municipality or country that legally recognizes such domestic partnerships or civil unions, and 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 about this plan, “Dow” refers to The Dow Chemical Company and certain of its subsidiaries and affiliates.

Dow Insured Health Program or Insured Health Program

The Dow Chemical Company Insured Health Program.

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Eligibility Determination Claims

Claims requesting a determination as to whether a claimant is eligible to enroll in Plan.

Employee

A person who:

- is employed by a Participating Employer to perform personal services in an employer-Employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute;
- receives a payment for services performed for the Participating Employer directly from the Participating Employer’s or the Company’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 Dow Chemical Company as having regular Full-Time active status.

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 the Participating Employer’s or the Company’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.

Employer

Employer means Dow.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Full-Time

An Employee classified by Dow or a Participating Employer as having Full-Time status.

HIPAA

The U.S. Health Insurance Portability and Accountability Act of 1996.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a nonprofit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
 - is run according to rules established by a group of professional persons;
 - maintains clinical records on all patients;
 - does not primarily provide custodial care or care and treatment of the mentally ill;
- but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CGLIC; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;

- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency;
- a Free-standing Surgical Facility; or
- a licensed birthing center.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; or (b) surgery;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received;
- Partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Infertility

The term Infertility means the inability to conceive during a continuous 12-month period of unprotected sexual intercourse.

Initial Claims Reviewer

The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is CGLIC. The Initial Claims Reviewer with respect to deciding a Claim for Eligibility Determination is the Senior International Benefits Manager.

Injury

The term Injury means an accidental bodily injury.

Less-than-Full-Time Employee

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

Mail-Order Pharmacy

The term Mail-Order Pharmacy means a pharmacy designated as a primary distribution center for a mail-service 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 Section 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.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

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-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.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Participant

An Employee, Retiree, Surviving Spouse of Record/Surviving Domestic Partner of Record, 60 Point Retiree Medical Severance Plan Participant, or 65 Point Retiree Medical Severance Plan Participant who participates in the Program because he meets the eligibility criteria of the Program.

Participating Employer

The Dow Chemical Company or one of its subsidiaries or affiliates, with which the Company's International Relocations Department is coordinating, or has coordinated, an international relocation of an employee of the Company or one of its subsidiaries or affiliates to another job assignment. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Controlled Group. If the entity ceases to be a member of the Controlled Group, then the entity ceases to be a "Participation Employer" on the date it is no longer a member of the "Controlled Group". "Controlled Group" is with respect to The Dow Chemical Company, and means a controlled group of corporations or entities within the meaning of section 414(b) or section 414(c) of the Code.

Participating Mail-Order Pharmacy

The term Participating Mail-Order Pharmacy means a Mail-Order Pharmacy which has contracted directly or indirectly with CGLIC on behalf of RxPRIME.

Participating Retail Pharmacy

The term Participating Retail Pharmacy means a Retail Pharmacy which has contracted directly or indirectly CGLIC on behalf of RxPRIME.

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Plan

International Medical and Dental Plan of The Dow Chemical Company Insured Health Program.

Plan Administrator

Each of the Vice President of Compensation and Benefits, Associate Director of Dow North America, the U.S. Health and Welfare Leader, the Senior International Benefits Manager and such other person, group of persons or entity which may be designated by the Plan Sponsor in accordance with the Plan Document.

Plan Document

means the Plan Document for International Medical and Dental Plan of The Dow Chemical Company Insured Health Program. The summary plan description for the Plan is an integral part of the Plan Document.

Plan Year

The 12-consecutive-month period beginning January 1 and ending December 31 of the next year.

Prescription Legend Drug

The term Prescription Legend Drug means any medicinal substance requiring, under the Federal Food, Drug and Cosmetic Act, a label that reads: "Caution: Federal law prohibits dispensing without a prescription."

Prescription Order

The term Prescription Order means the request for each separate drug or medication by a Physician or each authorized refill of such request.

Program

The Dow Chemical Company Insured Health Program.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

QMSCO

A QMSCO 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 QMSCO applies, the child is eligible for coverage as your Dependent. You can obtain a free copy of the Program's QMSCO 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 Section 1 of this SPD, entitled "ERISA Section".)

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CGLIC.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Regular Employee

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

Retail Pharmacy

The term Retail Pharmacy means any pharmacy other than a pharmacy designated as a primary distribution center for a mail service program.

Retiree

An Employee who was, as of the date of his termination of employment with a Participating Employer: (1) age 50 or older with at least 10 years of Service, and (2) not immediately transferred to another Participating Employer, or to a subsidiary or affiliate of the Company that is 80% or more owned by the Company, or to one of the Participating Employer's subsidiaries or affiliates.

Retirement Date

The date on which an active Employee who is age 50 or older with at least 10 years of Service terminates employment with a Participating Employer if such Employee becomes a Retiree on that date.

Salaried Individual

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

Service

The period of time an individual worked for a subsidiary(ies) or affiliate(s); provided, that the Company owned at least 50% of such subsidiary(ies) or affiliate(s) at the time the individual worked for the subsidiary(ies) or affiliate(s).

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Significant Break In Coverage

Sixty-three consecutive days during which an individual does not have any Creditable Coverage under HIPAA.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis; but only if that institution:
(a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Spouse

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

Spouse of Record

For Retirees who were eligible for coverage under the Program prior to January 1, 2003, "Spouse of Record" means the person who was Married to the Retiree on December 31, 2002.

For Retirees who become eligible for coverage under the Program on or after January 1, 2003, "Spouse of Record" means the person who was Married to the Retiree on the Retiree's last day on the payroll.

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

Summary Plan Description ("SPD")

The summary plan description for the Program. The summary plan description is an integral part of the Plan Document for the International Medical and Dental Plan of The Dow Chemical Company Insured Health Program

Surviving Spouse/Domestic Partner

The widowed Dependent Spouse/Domestic Partner of an Employee who participated in the Program if such Spouse/Domestic Partner was a covered Dependent at the time of the death of such Employee.

Surviving Spouse/Domestic Partner of Record

The widowed Dependent Spouse/Domestic Partner of Record of an Employee or Retiree who participated in the Program if such Spouse/Domestic Partner of Record was an eligible Dependent at the time of the death of such Employee or Retiree.

Survivor

A Surviving Spouse/Domestic Partner or a Surviving Spouse of Record/Domestic Partner of Record.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Termination of Domestic Partnership

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

APPENDIX A

NOTICE OF PRIVACY PRACTICES CIGNA International Expatriate Benefits*

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

PLEASE REVIEW THIS NOTICE CAREFULLY

This notice will become effective on April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

CIGNA* is dedicated to maintaining the privacy of your, individually identifiable health information (sometimes referred to as Protected Health Information ("PHI")) In conducting our business, we will create and maintain certain records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your individually identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- how we may use and disclose your individually identifiable health information;
- your privacy rights regarding your individually identifiable health information;
and
- our obligations concerning the use and disclosure of your individually identifiable health information.

*CIGNA refers to CIGNA Corporation and/or one or more of its subsidiaries. CIGNA Corporation is a holding company and is not an insurance or an operating company. CIGNA International Expatriate Benefits ("CIEB") refers to various operating subsidiaries of CIGNA Corporation, which qualify as a covered entity under HIPAA. Products and services are provided by these subsidiaries and not by CIGNA Corporation. Most employees are employed by such subsidiaries and not by CIGNA Corporation. CIGNA® is a registered servicemark of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its subsidiaries.

The terms of this notice apply to all records containing your individually identifiable health information that are created and/or retained by our organization. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all your records that our organization has created and/or maintained in the past, and for any of your records that we may create and/or maintain in the future. You may request a copy of our most current notice at any time by sending a written request to Privacy Office, 590 Naamans Road, Claymont, DE 19703 and/or review our Notice of Privacy Practices on our web site at <http://www.cigna.com/general/misc/privacy.html>.

LAW APPLICABLE TO THE UNITED STATES

HIPAA is a United States Federal law that generally applies to health plans, healthcare clearing houses, and health care providers (“Covered Entities”) and governs how these Covered Entities use and disclose certain information.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT

Privacy Office
CIGNA International Expatriate Benefits
590 Naamans Road
Claymont, DE 19703
Telephone Number: (302) 797.3100 or 1.800.441.2668

WHAT IS CONFIDENTIAL INFORMATION

CIGNA* receives health information that is needed to provide health benefits, administer your health plan and conduct general insurance business. You provide us with this information when you apply for coverage or submit a claim. Additional information is received from your health care providers, your employer, and vendors acting on behalf of your employer. CIGNA International Expatriate Benefits is required by law to protect the privacy of confidential information and to provide you with this Notice of Privacy Practices.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and/or disclose your identifiable health information.

TREATMENT

CIGNA* may use and/or disclose your individually identifiable health information to doctors, dentists, pharmacies, hospitals and other health care providers for treatment purposes. For example, your provider may ask you to undergo laboratory tests such as blood or urine tests and use the results to help reach a diagnosis. Many of the people who work for your provider may use and/ or disclose your individually identifiable health information in order to treat you and/or to assist others in your treatment. Additionally, we may disclose your individually identifiable health information to others who may assist in your care, such as your therapist, spouse, children, or parents.

PAYMENT

CIGNA* may use and/or disclose your individually identifiable health information in order to pay for the services and items you may receive. For example, we may contact your health provider to certify that you received treatment and for what range of benefits, and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We may also use and disclose your individually identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members.

HEALTH CARE OPEARATIONS

CIGNA* may use and/or disclose your individually identifiable health information to operate our business. For example, our claims administrator may use your health information to evaluate the quality of care you received from your provider, or to conduct cost-management and business planning activities for our organization.

PLAN SPONSORS

CIGNA* may use and/or disclose individually identifiable health information to a plan sponsor for plan administration functions performed by a plan sponsor on behalf of the Health Plan. The Health Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the plan.

VENDORS

CIGNA* may disclose your individually identifiable health information to companies with whom we contract to perform services on our behalf.

DISCLOSURES TO OTHER COVERED ENTITIES

CIGNA* may disclose individually identifiable health information to other covered entities, or business associates of those entities for treatment, payment and certain health

care operations purposes. For example, we may disclose individually identifiable health information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

MARKETING INFORMATION

If CIGNA* meets with you in person, we may use and disclose your individually identifiable health information to encourage you to purchase or use a product or service that is not part of the health benefits we provide. In addition, we may use and disclose your individually identifiable health information to provide you with a promotional gift of nominal value.

USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN SPECIAL CIRCUMSTANCES

PUBLIC HEALTH ACTIVITIES

CIGNA* may use/and or disclose your individually identifiable health information to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths;
- reporting child abuse or neglect;
- preventing or controlling disease, injury or disability;
- notifying a person regarding potential exposure to a communicable disease;
- notifying a person regarding a potential risk for spreading or contracting a disease or condition;
- reporting reactions to drugs or problems with products or devices;
- notifying individuals if a product or device they may be using has been recalled;
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the insured agrees or we are required or authorized by law to disclose this information; and
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

HEALTH OVERSIGHT ACTIVITIES

CIGNA* may use and/or disclose your individually identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

RESEARCH

CIGNA* may use and/or disclose your individually identifiable health information for research purposes, subject to strict legal restrictions.

LAW ENFORCEMENT

CIGNA* may use and/or disclose individually identifiable health information, in certain situations.

LAWSUITS, JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

CIGNA* may use and/or disclose your individually identifiable health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding.

HEALTH OR SAFETY

CIGNA* may, consistent with applicable law and ethical standards of conduct, use and/or disclose your individually identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only use/or make disclosures to a person or organization able to help prevent the threat.

MILITARY OR SPECIALIZED GOVERNMENT FUNCTIONS

CIGNA* may use and/or disclose your individually identifiable health information to appropriate military command authorities or the U.S. Department of State if you are a member and/or a veteran of U.S. or foreign military forces.

WORKERS' COMPENSATION

CIGNA* may use and/or disclose your individually identifiable health information for workers' compensation and similar programs.

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

CIGNA* will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and/or disclosure of your individually identifiable health information may be revoked at any time by providing us written notice at the address set forth in the beginning of this notice. After you revoke your authorization, we will no longer use and/or disclose your individually identifiable health information for the reasons described in the authorization, except for the following circumstances.

- We have taken action in reliance on your authorization before we received your written revocation;
- You were required to give us your authorization as a condition of obtaining coverage; or
- If state law gives us the right to contest a claim under your policy.

Note: we are required to retain records of your care.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the individually identifiable health information that we maintain about you:

- You have the right to request that our office communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, please submit your request in writing to the address set forth in the beginning of this notice. We will accommodate reasonable requests whenever feasible.
- You have the right to request a restriction in our use or disclosure of your individually identifiable health information for treatment, payment, or health care operations. While we will consider all requests for restrictions, we are not required to agree to your request. Please submit your written request to the address set forth in the beginning of this notice and include the following:
 - The information you wish restricted;
 - Whether you are requesting to limit our organization's use, disclosure or both;
 - To whom you want the limits to apply.
- You have the right to inspect and obtain a copy of the individually identifiable health information that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the address set forth in the beginning of this notice in order to inspect and/or obtain a copy of your identifiable health information. We may charge a fee for copying and mailing costs.
- You may ask us to amend your individually identifiable health information if you believe it is incorrect or incomplete for as long as the information is kept by our organization. If we determine that the record is inaccurate or incomplete and the law permits us to amend it, we will correct the information that is affected. If your physician or other health care provider created the information that you desire to be changed, you should contact such physician/provider to request that the information

be amended. You must submit your request in writing to the address set forth in the beginning of this notice in order for us to amend you health information.

- All of our insureds have the right to request an “accounting of disclosures,” which is a list of certain disclosures our organization has made of your individually identifiable health information excluding those disclosures made for treatment, payment or health care operations. All requests for “accounting of disclosures” must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.
- You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice please, contact the Privacy Office at the address set forth in the beginning of this notice

RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our organization, please submit your concern(s) in writing to our Privacy Office to the address set forth in the beginning of this notice. We will not retaliate against you if you choose to file a complaint directly with us or with the Secretary of the United States Department of Health and Human Services.

Appendix B

Important Notice of Creditable Coverage For Medicare-Eligibles Applicable to Plan Year 2012

The International Medical and Dental Plan *does* provide *Creditable* Coverage for prescription drugs.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

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. If you were enrolled in the Old Plan or New Plan, you may not re-enroll in either the Old Plan or the New Plan unless you were enrolled in a Dow approved Medicare Advantage-PD (an HMO) that provides prescription drug coverage. Check the applicable summary plan description for details.

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