

**Summary Plan Description for:**

**Union Carbide Corporation  
Retiree Medical Care Program**

**Self-Funded HMO Plans**

**(ERISA Plan #540)**

**Applicable to  
Pre-Medicare-eligible Retirees**

*Amended and Restated: April 19, 2011*

*Effective January 1, 2011 and thereafter until superseded*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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## Section 1. ERISA Information

### Summary Plan Description for Union Carbide Corporation Retiree Medical Care Program Self-Funded HMO Plans (“Plan”)

<b>Plan Sponsor:</b>	Union Carbide Corporation c/o The Dow Chemical Company Employee Development Center Midland, Michigan 48674
<b>Employer Identification Number:</b>	13-1421730
<b>Plan Number:</b>	540
<b>Plan Administrator:</b>	U.S. Health and Welfare Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 Attention: Medical Plan (CIGNA Self-Funded Plan)
<b>Claims Administrators for Claims for Plan Benefits:</b>	<p>With respect to claims and questions concerning benefits coverage, contact the applicable Self-Funded HMO Plan administrator:</p> <p>Blue Care Network PO Box 68767 Grand Rapids, MI 49516-8767 1 (800) 662-6667 <a href="http://www.mibcn.com">www.mibcn.com</a></p> <p>Blue Cross/Blue Shield of Michigan (Illinois) National Customer Service Center Mail Code B455 600 Lafayette East Detroit, MI 48226-2998 1 (800) 752-1455 <a href="http://www.bcbsmi.com">www.bcbsmi.com</a></p> <p>CIGNA HealthCare PO Box 182223 Chattanooga, TN 37422 1-800-244-6224 <a href="http://www.myCIGNA.com">www.myCIGNA.com</a></p> <p>HealthPartners Administrators, Inc. PO Box 1289 Minneapolis, MN 55440-1289 (952) 883-5000 or 1-800-883-2177 <a href="http://www.healthpartners.com">www.healthpartners.com</a></p>

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	<p>Humana Claims Office  P.O. Box 14601  Lexington, KY 40512-4601  1 (800) 448-6262  <a href="http://www.humana.com">www.humana.com</a></p>
<p><b>Claims Administrator for Claims for an Eligibility Determination:</b></p>	<p>With respect to claims concerning eligibility to participate in the Plan:  U.S. Health and Welfare Leader  The Dow Chemical Company  Employee Development Center  Midland, Michigan 48674  (800) 344-0661 or (989) 636-0977</p>
<p><b>Retiree Service Centers</b></p>	<p>The Dow Chemical Company  Employee Development Center  Midland, Michigan 48674    (800) 344-0661 or for callers outside the continental U.S.  (989) 636-0977</p>
<p><b>To Apply For or to Appeal Denial of a Claim:</b></p>	<p>To appeal a denial of Claim for an Eligibility Determination, see Claims Procedures section of this SPD.</p> <p>To appeal a denial of a Claims for a Plan Benefit:</p> <p>Blue Care Network  Grievance and Appeals Unit  Mail Code C248  PO Box 284  Southfield, MI 48086</p> <p>Blue Cross/Blue Shield of Michigan (Illinois)  Grievance and Appeals Unit  PO Box 2627  Detroit, MI 48231-2627</p> <p>CIGNA Appeals Unit  PO Box 188011  Chattanooga, TN 37422</p> <p>Member Services Dept.  HealthPartners Administrators, Inc.  PO Box 1309  Minneapolis, MN 55440-1309</p> <p>Humana Grievance and Appeals  P.O. Box 14546  Lexington, KY 40512-4546</p>
<p><b>To Serve Legal Process File with:</b></p>	<p>General Counsel  Union Carbide Corporation  c/o The Dow Chemical Company  Employee Development Center  Midland, Michigan 48674</p> <p>Or</p> <p>Blue Care Network Service Company  20500 Civic Center Dr.  Mail Code C 467  Southfield, MI 48076</p>

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	<p>Blue Cross/Blue Shield Michigan (Illinois) 600 Lafayette East Detroit, MI 48226</p> <p>CIGNA HealthCare Legal Division W-26B 900 Cottage Grove Road Hartford, CT 06152</p> <p>Or</p> <p>HealthPartners Administrators, Inc. Sales Executive 8100 34<sup>th</sup> Ave. S. PO Box 1309 Minneapolis, MN 55440-1309 Attention: Law Department</p> <p>Or</p> <p>Humana 500 West Main St. Louisville, KY 40202</p>
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<b>COBRA</b>	<p>Ceridian COBRA Continuation Services (formerly known as CobraServ) administers the COBRA requirements of the Plan under an administrative services agreement.</p> <p>Ceridian COBRA Continuation Services National Service Center 3201 34<sup>th</sup> Street South Saint Petersburg, Florida 33711-3828 (800) 877-7994</p>
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<b>Plan Year</b>	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
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<b>Funding</b>	<p>Union Carbide shares the costs with Retirees. Retiree contributions are made through pension check deduction or invoicing. Benefits are paid directly to Providers and/or Participants from, at the Company's discretion, either partially, entirely, or only, from: the Company's general assets. The Company's contribution to Program costs is limited to the retiree medical budget established in January 2000 and July 2003. Participant contributions will be used in their entirety to pay benefits prior to using the Company's contributions to pay benefits.</p> <p>The assets of the Program, if any, can be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses can include, and are not limited to, consulting fees, actuarial fees, attorney fees, third-party administrator fees, and other administrative expenses.</p>
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## Section 2. Introduction

This is the *Summary Plan Description (SPD)* for the Self-Funded HMO Plans, which are plans offered under the Union Carbide Corporation Retiree Medical Care Program (“Program”) as applicable to eligible pre-Medicare-eligible Retirees, 60 Point Retiree Medical Severance Plan Participants, and LTD Participants.

Self-Funded HMO Plans are plans that have the same or similar plan design as an HMO, but are funded from UCC’s general assets. The HMO administers the Self-Funded HMO Plan under a contract with Dow or UCC. Self-Funded HMO Plans “look” and “feel” like HMOs in most respects, except that the medical expenses are paid from Dow’s or UCC’s general assets instead of the HMO’s. The Self-Funded HMO Plans described in this SPD are:

- Blue Care Network Self-Funded HMO
- Blue Cross/Blue Shield of Michigan (Illinois) Self Funded HMO
- CIGNA Self Funded HMO
- HealthPartners Self Funded HMO
- Humana Self Funded HMO

This SPD contains important information about benefits under the Plans. However, it does not contain all of the information. Further information can be found in the Plan Documents for the Union Carbide Corporation Retiree Medical Care Program. If there is a discrepancy between this *SPD* and the Plan Documents, the Plan Documents will govern. You may request a copy of either of the Plan Documents from the Plan Administrator. See the *ERISA Information* section of this *SPD* for the Plan Administrator’s name and address.

Union Carbide Corporation (“the Company” or “UCC”) reserves the right to amend, modify or terminate the Union Carbide Corporation Retiree Medical Care Program (and/or any of its underlying Plans) at any time at its sole discretion.

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

The provisions of this *SPD* only apply to the Self-Funded HMO Plans. Check the [www.dowfriends](http://www.dowfriends.com) website or call the Retiree Service Center at (800) 344-0661 or (989) 636-0977 for information about other plans available to eligible Retirees, 60 Point Retiree Medical Severance Plan Participants, and LTD Participants.

Words that are capitalized are either defined in the Plan Document for the Program or in the *Definitions of Term* section of this *SPD* or in the *Description of Benefits (Appendix A)* of this *SPD*. When used in this *Summary Plan Description* and communications to Employees, “Union Carbide” refers to Union Carbide Corporation and its subsidiaries and affiliates that Union Carbide Corporation has authorized to participate in the Program.

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

## Section 3. Eligibility

### 3.1 Self-Funded HMO Plans

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Besides meeting the eligibility requirements of this section, you must reside in the geographic locations where a Self Funded HMO is available.

- Blue Care Network is available in Michigan.
- Blue Cross/Blue Shield of Michigan (Illinois) is available in Illinois
- CIGNA is available in Ohio, Texas, Illinois, New Jersey, North Carolina, or South Carolina.
- HealthPartners Minnesota is available in Minnesota
- Humana is available in Louisiana

### 3.2 The Self-Funded HMO Plans are Available to Only to Pre-Medicare Retirees

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The Self-Funded HMO Plans are not available to you if you are eligible for Medicare.

### 3.3 Eligibility

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#### Retiree Definition

A “Retiree” is defined as:

- For individuals who retired under the Union Carbide Employees’ Pension Plan (formerly known as the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries, and also referred to as “UCEPP”) prior to the acquisition of Union Carbide Corporation by The Dow Chemical Company (February 6, 2001), a Retiree is defined as: an employee who has terminated from Union Carbide (and is not employed by a successor employer or a divested or joint venture business) and was eligible at the time of his or her termination, due to meeting age and service requirements of the Union Carbide Employees’ Pension Plan, to immediately commence his or her pension benefit and continue participation in the Company’s medical plans.
- Until and through February 5, 2001, for individuals who were employed by the Company prior to February 6, 2001, and became “retirees” under the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries (as “retiree” is defined under that retirement program) prior to February 6, 2001, (and were not employed by a successor employer or a divested or joint venture business), a Retiree also includes a former Employee who was involuntarily terminated by action of a Participating Employer and:
  - was age 48 or older with at least 8 years of service or age 60 or older with at least 8 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and commenced a benefit under the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries at the time of termination of employment, or

- was age 47 or older with at least 7 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under a severance program sponsored by the Company
- Until and through February 5, 2003, for individuals who were employed by the Company prior to February 6, 2001, and became “retirees” under the Union Carbide Employees’ Pension Plan (as “retiree” is defined under that retirement program) on or after February 6, 2001, a Retiree also includes a former Employee who:
  - was age 47 or older with at least 7 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under the Union Carbide Corporation Special Severance Protection Program.
- For individuals who terminate employment after February 6, 2001, a Retiree means a former Employee who:
  1. was age 50 or older with at least 10 years of Service at the time his employment terminated with a Participating Employer, who is also a “retiree” under the terms of the Union Carbide Employees’ Pension Plan, or
  2. has been Localized in the U.S. and:
    - a. is still a Localized U.S. Employee when his employment with a Participating Employer ends, and
    - b. is age 50 or older with 10 or more years of Service and his employment with a Participating Employer ends, and
    - c. at the time he was Localized in the U.S., he was eligible for Union Carbide Employees’ Pension Plan, although he need not participate in Union Carbide Employees’ Pension Plan or be vested in Union Carbide Employees’ Pension Plan at the time his employment ends, and
    - d. at the time his employment with the Participating Employer ends, he is not immediately transferred to an 80% or more owned Dow subsidiary or affiliate.

An Employee who was at least age 50 or older with 10 or more years of Service at the time employment with the Participating Employer ends, and whose pension assets in the Union Carbide Employees’ Pension Plan were transferred to a pension plan of an entity that is not a Participating Employer is not considered “retired” under the terms of the Union Carbide Employees’ Pension Plan. Such former Employee does not meet the Program’s definition of “Retiree”.

## Retiree Eligibility

A “Retiree’s” eligibility for coverage depends on a number of factors<sup>1</sup>:

1. The Retiree must have been hired prior to January 1, 2008<sup>2</sup>; and

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<sup>1</sup> If your employment with a Participating Employer began as a result of an acquisition by Union Carbide Corporation or an affiliate of UCC on or after January 22, 2007, or your employer was acquired by Union Carbide or an affiliate of UCC on or after January 22, 2007, you are not eligible for coverage.

<sup>2</sup> If your employment with a Participating Employer terminated prior to January 1, 2008 (referred to as your “pre-January 1, 2008 termination date”), and you are subsequently re-hired by a Participating Employer, your first hire-date will be recognized by the Plan only if 1) you become a participant of the UCEPP component of the Union Carbide Employees’ Pension Plan after your re-hire date, or 2) you were eligible for coverage under the Program as of your pre-January 1, 2008 termination date because you were a Retiree, 60 Point Retiree Medical Severance Plan Participant or a 65 Point Retiree Medical Severance Plan Participant, and after re-hire, you did not become a participant of the UCEPP component of the Union Carbide Employees’ Pension Plan, but instead became a participant of the Personal Pension Account component of the Union Carbide Employees’ Pension Plan.

2. The Retiree's employer must have been a Participating Employer prior to January 1, 2008; and
3. The Retiree must have been eligible as an active Employee immediately preceding Retirement under The Dow Chemical Company Medical Care Program or The Dow Chemical Company Insured Health Program or, if Retirement occurred prior to January 1, 2002, a Union Carbide-sponsored medical plan.
4. Eligibility for certain Plans is dependent on whether the Retiree is eligible for Medicare.
5. Eligibility for coverage after the Retiree is eligible for Medicare is only offered to those whose hire date with a Participating Employer was prior to February 6, 2001.
6. You are not eligible for coverage under the Program if you are eligible for coverage as an employee or retiree under another medical program or medical support program sponsored by Union Carbide or Dow or any entity that is 50% or more owned by Dow (except that you may participate in The Dow Chemical Company Retirement Health Care Assistance Plan; and you may participate in a plan offered under The Dow Chemical Company Insured Health Program, provided the plan is not the International Medical and Dental Plan; and if you were an Americas Styrenics LLC employee, you may be eligible for the Americas Styrenics LLC Retiree Reimbursement Account Plan as long as you never elect to participate in that plan after terminating employment with Americas Styrenics LLC).

If you are a Retiree who is NOT eligible for Medicare, then you are eligible for any HMO/insured plan offered under the Program that permits pre-Medicare participants, as long as you meet the eligibility requirements listed above.

If you are a Retiree who IS eligible for Medicare, then your date of hire with a Participating Employer will be the determining factor:

- If you were hired prior to February 6, 2001, then you are eligible for coverage under the Program, as long as you meet the eligibility requirements listed above.
- If you were hired on or after February 6, 2001, then you are not eligible for coverage under the Program.

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

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

## **Survivor Eligibility**

See section of this SPD entitled *Survivor Benefits*.

## Disabled Participants

Except as otherwise provided<sup>3</sup>, if you are an Employee who has been approved to receive a benefit under The Dow Chemical Long Term Disability Income Protection Plan (LTD), you may also be eligible.

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

If you have less than ten (10) years of Service, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends prior to the expiration of the 12 month or 24 month period if you no longer qualify for LTD status. The 12 month period applies if you have less than one (1) year of Service. The 24 month period applies if you have more than one (1) year of Service, but less than ten (10) years of Service. If you have ten (10) or more years of Service, you are eligible for coverage until you are no longer eligible to receive payments from LTD.

You will be required to pay the same premiums active Employees pay. If you die while you are still eligible for the 12 or 24 month period of medical coverage, your surviving Spouse of Record/Domestic Partner of Record may continue coverage at the active Employee premium for the remainder of the 12 or 24 month period, whichever is applicable. After the expiration of the remainder of the 12 or 24 month period, the surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan’s COBRA rules. If you have ten (10) or more years of Service and you die when you are still eligible for medical coverage, your surviving Spouse of Record/Domestic Partner of Record should check the survivor rules in the medical plan.

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

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

## Disability under Union Carbide Employees’ Pension Plan

If you have been approved for disability retirement benefits under the UCEPP component of the Union Carbide Employees’ Pension Plan on or after February 7, 2003, you may also be eligible. Your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level that you had when you were an active Employee. Eligibility under this provision ends if you no longer have “disability retiree” status under the UCEPP component of the Union Carbide Employees’ Pension Plan. Currently, if the effective date of your disability retirement under the UCEPP component of the Union Carbide Employees’ Pension Plan is on or after February 7, 2003 but prior to January 1, 2006, UCC pays the full premium. Your medical plan and coverage level will be the Plan and coverage level most comparable to the last Plan and coverage level you had when you were an active Employee. Effective January 1, 2006, if the effective date of your disability retirement status under the UCEPP component of the Union Carbide Employees’ Pension Plan is on or after January 1, 2006, UCC provides you a premium subsidy at the Full Service level, regardless of your actual years of service. You are required to pay a premium based on the Retiree Medical Support Schedule and the Retiree Medical Budget.

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<sup>3</sup> If you are receiving LTD payments because of your employment with The Dow Chemical Company or Rohm and Haas Company, you are not eligible for coverage under the Union Carbide Retiree Medical Care Program or the Union Carbide Insured Health Program. Instead, medical coverage is available to you and your dependents under either The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program or the Rohm and Haas Company Health and Welfare Plan, whichever is applicable.

## **Disability Participant or a Retiree Can't Carry an Active Employee**

A Long Term Disability Participant or a Retiree may not carry a full-time active Employee as a Dependent under the Union Carbide Corporation Retiree Insured Health Program.

## **60 Point Retiree Medical Severance Plan Participants**

If you meet the definition of “60 Point Retiree Medical Severance Plan Participant”, you are eligible to participate in the Union Carbide Corporation Retiree Insured Health Program. A 60 Point Retiree Medical Severance Plan Participant is subject to the same terms and conditions, and rights and privileges, under the Program as a Retiree.

## **Special Eligibility Provisions for Mergers and Acquisitions and Other Special Situations**

If you were a part of a merger or acquisition, or a joint venture or other special business arrangement or situation, special rules may apply. Check Article III of the Plan Document. The Plan Document rules prevail over this SPD.

## **Eligibility If You or Your Dependents Are Eligible for Medicare**

If you are eligible for Medicare, you are not eligible for coverage under a Self-Funded HMO Plan. You may still be eligible for coverage under the Union Carbide Corporation Retiree Medical Care Program or the Union Carbide Corporation Insured Health Program if you meet the eligibility requirements of those Programs. You should check the summary plan descriptions of those Programs. If you are not eligible for coverage under one of those Programs, your Spouse of Record/Domestic Partner of Record may be able to continue coverage under a Self-Funded HMO Plan under the following circumstances. If your Spouse of Record/Domestic Partner of Record is not eligible for Medicare and was covered under the Plan at the time your coverage under the Plan ended due to your Medicare-eligibility, your Spouse of Record/Domestic Partner of Record may continue coverage under the Plan until your Spouse of Record/ Domestic Partner of Record becomes eligible for Medicare. The premium is 102% of the full unsubsidized cost to insure based on your Spouse of Record/ Domestic Partner of Record's age. Once your Spouse of Record/ Domestic Partner of Record is eligible for Medicare, your Spouse of Record/ Domestic Partner of Record loses coverage under the Plan. If your Spouse of Record/Domestic Partner of Record becomes eligible for Medicare before you do, then your Spouse of Record /Domestic Partner of Record loses coverage at the time your Spouse of Record/ Domestic Partner of Record becomes eligible for Medicare. Dependent children may continue coverage during the period requiring the 102% premium at a corresponding 102% rate.

Please refer to Section 4.5 and 4.6 of this SPD for information on what you need to do when you become Medicare-eligible.

## **Exclusions:**

You are not eligible for coverage under the Program if you are eligible for coverage under any other Union Carbide or Dow-sponsored medical program that is available to Retired Employees, their Dependents, Surviving Spouses/Domestic Partners, or Surviving Spouses of Record/Domestic Partners of Record (except you may be eligible for the Union Carbide Corporation Insured Health Program).

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

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

### 3.4 Dependent Eligibility

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Eligible Retirees (and 60 Point Retiree Medical Severance Plan Participants and LTD Participants) can enroll their eligible Dependents. A Dependent may be either your Spouse of Record or Domestic Partner of Record or an eligible child. The Retiree (or 60 Point Retiree Medical Severance Plan Participant or LTD Participant) must be enrolled in order to enroll a Dependent Spouse of Record/Domestic Partner of Record or Dependent child. See also section entitled *Pre and Post-Medicare Family*.

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

- your birth or legally adopted child; or
- your Spouse’s or Domestic Partner’s natural or adopted child; or
- a child for whom you or your Spouse/Domestic Partner or your Spouse of Record/Domestic Partner of Record have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently “legally relinquished all of their parental rights” in a court of law. “Legally relinquished all of their parental rights,” means that the biological parents permanently do not have the:
  - authority to consent to the child’s Marriage or adoption, or
  - authority to enlist the child in the armed forces of the U.S.;
  - right to the child’s services and earnings; and
  - power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child’s primary residence.

In addition to meeting the above requirements, in order to be 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 26<sup>th</sup> birthday, may continue coverage.

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

If you enroll your Spouse of Record/Domestic Partner of Record 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 Retiree has a “qualified medical child support order” for that child. A “Qualified Medical Child Support Order” (QMCSO) is a court order that meets the Program’s requirements. It gives a child the right to be covered under one of the Plans. Typically, a divorce decree that orders the Retiree to provide medical coverage for a specific child is a QMCSO, as long as the divorce decree also provides the following information. The Plan will also deem a divorce decree that orders the Retiree to provide medical coverage for a specific child a QMCSO if the following information is also provided with the divorce decree in a document signed by either the Retiree 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 Retiree 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 the Program’s rules).

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

If a QMCSO applies, the child is eligible for coverage as your Dependent. You can obtain a free copy of the Program’s QMCSO procedures, which explain how the Program determines whether a court order meets the Plan’s requirements, by requesting a copy from the Plan Administrator (listed in the ERISA Information section of this SPD).

## Dependent Child Exclusions

Your Dependent child will not be eligible for coverage under your Plan if he/she:

- ***is covered as a Dependent under a Dow-sponsored medical plan of another Employee or Retiree of Dow (or 60 Point or 65 Point Retiree Medical Severance Plan Participant or LTD Participant)*** – 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 26<sup>th</sup> 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 in Midland, at (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, contact the Retiree Service Center within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. If you qualify for a reduction in premium, the premium will be reduced effective the date you contact the Retiree Service Center, not the date of the event. The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

For information about rights your child may have for continuation of coverage under the Plan as provided by the federal COBRA law, see section entitled *Your Right to Continuation Coverage Under COBRA*.

## **Spouse of Record/Domestic Partner of Record Exclusions**

Your Spouse of Record/Domestic Partner of Record is not eligible for coverage under your Plan if he/she is:

- eligible for coverage as a full-time employee or retiree under another employer's<sup>4</sup> plan, but not enrolled for personal coverage in that plan (see the *Working or Retired Spouse of Record/Domestic Partner of Record Rule* section for details), or
- enrolled for coverage as an Employee or Retiree under another UCC or Dow-affiliated Plan, or
- serving in the armed forces of any country.

## **The Working or Retired Spouse of Record/Domestic Partner of Record Rule**

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

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

The following is required in order to have such coverage on your Spouse of Record/Domestic Partner of Record:

- the Spouse of Record/Domestic Partner of Record was enrolled in the Program at the normal premium when the Plan learns that she/he was eligible for his employer's/former employer's group health plan.
- the Spouse of Record/Domestic Partner of Record will be required to enroll in coverage through his or her employer's/former 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 of Record/Domestic Partner of Record at 102% of the cost of coverage.

If the two previous bulleted items are met, and you cover your Spouse of Record/Domestic Partner of Record, and then drop him or her from your UCC coverage, or fail to pay the 102% premium, you can not

re-enroll your Spouse of Record/Domestic Partner of Record until the next UCC open enrollment period that occurs after your Spouse of Record/Domestic Partner of Record has enrolled in his or her plan.

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

### **Waiving Coverage—Working or Retired Spouse of Record/Domestic Partner of Record**

If your Spouse of Record/Domestic Partner of Record has coverage through his or her employer/former employer, you may choose to waive coverage for him or her under the Plan offered by UCC in order to save premium dollars.

### **Exception to the Working or Retired Spouse of Record/Domestic Partner of Record Rule**

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

### **Remarriage or 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 UCC sponsored retiree medical program.

## **3.5 Eligibility Determinations of Claims Administrator are Final and Binding**

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The applicable Claims Administrator determines eligibility. The applicable Claims Administrator is a fiduciary of the Program and 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 *Claims Procedures* section of this SPD.

## **Section 4. Retiree Enrollment**

### **4.1 Retirees: Levels of Participation**

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The levels of participation available are:

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

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

The Retiree must be enrolled in order to enroll a Dependent Spouse of Record/Domestic Partner of Record or Dependent child. The Retiree may only enroll the Dependent in same plan that the Retiree is enrolled in. A Dependent may not be enrolled in a UCC sponsored plan that is different than the Retiree. For example, if the Retiree is enrolled in CIGNA Self-Funded HMO Plan, the Dependent cannot be enrolled in MAP Plus. The Dependent may only be enrolled in the same plan that the Retiree is enrolled in, in this example, CIGNA Self-Funded HMO Plan.

\* or 60 Point Retiree Medical Severance Plan Participant or LTD Participant

## 4.2 Enrolling at Retirement

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To enroll for Program coverage, complete an enrollment form at the time of your Retirement and return it to the U.S. Benefits Center within 31 days of your Retirement. If you do not enroll yourself and/or your eligible Dependents within the 31 day period, you and/or they will not be covered. You may also enroll within 90 days of your termination of employment – See section entitled “Mid Year Election Changes”. You will have another opportunity to enroll during annual enrollment. 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.**

## 4.3 Retiree Annual Enrollment

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Enrollment is typically held during the last quarter of the year. You can enroll for coverage, switch from a Self-Funded HMO Plan to another Self-Funded HMO Plan, another self-insured plan sponsored by UCC, or an HMO offered by UCC’s insured medical program, or waive coverage at this time. If you wish to add a Dependent, either a Spouse of Record/Domestic Partner of Record or an eligible child during annual enrollment, you must make sure that your coverage level is appropriate when you enroll. If you are adding a Spouse of Record/Domestic Partner of Record, be sure that he/she meets the definition of Spouse of Record/Domestic Partner of Record in the *Definitions* section of this SPD.

If, at annual enrollment, you do not have employer/former employer or private individual coverage, you may not enroll in a Self-Funded HMO Plan. However, you should check to see if you can enroll in UCC’s Catastrophic Medical Plan by calling the Retiree Service Center or checking the summary plan description for the UCC Retiree Medical Care Program’s Catastrophic Medical Plan. In order to be eligible for the CIGNA Self-Funded Plan, you must have been covered under the UCC Catastrophic Medical Plan for a period of two years immediately prior to enrolling in a Self-Funded HMO Plan.

If, at annual enrollment, you have other employer/former employer or private individual coverage, you may enroll in any Plan. You must submit proof of other coverage at that time, i.e., HIPAA certificate or a letter from the employer or insurance company.

If you miss the annual enrollment deadline, you still may be able to cover yourself and your Dependents if you meet the following requirements:

- If you are enrolling your Dependent, you also must be enrolled in the Program;
- If you are adding a Dependent, you must submit the required documentation to show proof of Dependent eligibility;

- If you are adding a Dependent and/or enrolling yourself, you must pay a premium equal to 102% of the full cost to insure retroactive to January 1 of the applicable plan year and for the remainder of the calendar year.

The 102% premium requirement applies even if you currently are enrolled for Retiree plus Spouse of Record and Child(ren) level coverage, Retiree plus Domestic Partner of Record and Child(ren) level coverage or Retiree plus Child(ren) coverage. Coverage will be effective retroactive to the beginning of the applicable plan year.

The Program reserves the right at any time to request proof of Dependent eligibility (such as a birth certificate, passport, Marriage certificate, proof of Domestic Partner of Record 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.

## 4.4 Dual Dow/UCC Coverage

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

- You may each enroll separately, or one of you may enroll the other as a Dependent; except that a full-time active Employee may not be enrolled in a Retiree Medical plan.
- If you each enroll separately, either of you, but not both, may enroll your eligible Dependent children (this rule also applies to divorced parents who are independently eligible for coverage)
- If you each enroll separately, your Deductibles and Out-of-Pocket Maximums will be calculated separately (this rule also applies to divorced parents who are independently eligible for coverage)

## 4.5 What if I Am Enrolled in a Self-Funded HMO Plan, and I become eligible for Medicare?

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If you are enrolled in a Self-Funded HMO Plan and you or your Spouse of Record/Domestic Partner of Record become eligible for Medicare, your coverage with the Self-Funded HMO Plan automatically ends. If you are a Retiree who was hired by the Company prior to February 6, 2001, you may switch to another plan. No proof of insurability is required. You must enroll in Medicare Parts A and B as soon as eligible. Contact the Retiree Service Center (see *ERISA Information* section of this SPD for contact information).

Except as otherwise provided under the Program, Retirees who were hired on or after February 6, 2001, are not eligible to participate in any plan offered under either Union Carbide Corporation Retiree Medical Care Program or Union Carbide Corporation Insured Health Program once they become eligible for Medicare.

If you are not eligible to participate in a UCC retiree medical plan, you should enroll in Medicare Parts A and B, or a Medicare Advantage HMO. (Note, you are not eligible to enroll in a Medicare Advantage HMO offered under the Union Carbide Corporation Insured Health Program). You should also consider enrolling in Medicare Part D. Failure to enroll in Medicare within the Medicare deadlines may result in Medicare-imposed penalties.

## 4.6 Pre-February 6, 2001 -Hires: Requirement to Enroll in Medicare

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If you were hired prior to February 6, 2001, you and/or your Spouse of Record/Domestic Partner of Record must be enrolled in Medicare in order to be eligible for coverage under the Union Carbide Corporation

Retiree Medical Care Program or the Union Carbide Corporation Insured Health Program. Note that once you are eligible for Medicare, you are no longer eligible for coverage under Self-Funded HMO Plan.

### **Participant Less than 65 Years of Age**

If you were hired prior to February 6, 2001, during the three month period before you reach age 65, you need to enroll in Medicare Parts A and B in order to be eligible for any UCC-sponsored plan available to Medicare-eligible Retirees. The same guidelines apply for your Spouse of Record/Domestic Partner of Record.

**Note:** If you or your Spouse of Record or Domestic Partner of Record become eligible for Medicare due to disability, or for any other reason, before you reach age 65, you must enroll in Medicare parts A and B within the deadlines set by Medicare or you must enroll in Medicare HMO offered under the UCC Insured Health Program. The above described Medicare enrollment is required in order to be eligible for coverage under any Dow-sponsored plan. Your Dependents who are eligible for Medicare are also required to enroll in Medicare as described above.

## **4.7 Special Enrollment Provisions**

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If you decline enrollment in coverage under the Program for yourself or your Dependents (including your Spouse of Record/Domestic Partner of Record because you or your Dependents have other health insurance coverage, you may in the future enroll yourself or your eligible Dependents outside of UCC'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 UCC- sponsored coverage, you or your eligible Dependent must enroll in the UCC- sponsored coverage within 90 days after the other coverage ends. However, if you or your Dependent declined UCC- sponsored coverage because of other coverage provided through COBRA, you or your Dependent must wait until UCC's open enrollment period unless the entire period of coverage available under the COBRA coverage has been exhausted. An individual need not elect COBRA coverage under another health plan in order to use these special enrollment provisions. Proof of eligibility is required within the 90-day period.

If you have a new Dependent as a result of Marriage, Domestic Partnership, birth, adoption or placement for adoption, you may receive coverage under the Program for yourself and your Dependent if you enroll in the Program 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.

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.

## **4.8 If You Move During the Plan Year**

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If you move during the Plan Year and a Self-Funded HMO Plan is not offered at your new location, you may switch your coverage to a UCC- sponsored plan that is available at your new location.

## Section 5. Retirees: Mid-Year Election Changes

You may **drop** a Dependent from coverage or waive coverage for yourself at any time. However, you may not drop a Spouse of Record in anticipation of a divorce. If you want to **add** a Dependent mid-year, you must have BOTH a “change in status” AND you must meet all of the consistency rules (except as otherwise provided below). The Program administers changes in status event and the consistency rules the same way with respect to Domestic Partners of Record as Spouses of Record, to the extent that such administration does not jeopardize the tax qualified status of the Program.

### 5.1 Change in Status

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

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

### 5.2 Consistency Rule

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

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

#### Exceptions:

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

- **Court Orders** - You may change your election mid-year if a court order resulting from a divorce, annulment, or change in legal custody (including a Qualified Medical Child Support Order “QMCSO”), requires a change in your medical plan election.
- **Significant Cost or Coverage Changes** – If your Spouse of Record/Domestic Partner of Record is covered by his/her employer’s plan, and your Spouse of Record/Domestic Partner of Record’s employer allows him/her to change his/her benefit plan election because of a significant change in cost of coverage under your Spouse of Record/Domestic Partner of Record’s employer’s plan, such change

in your Spouse of Record/Domestic Partner of Record's election will allow you to change your Plan coverage level. If your Spouse of Record/Domestic Partner of Record's employer's enrollment period is different from UCC's, your Spouse of Record/Domestic Partner of Record's election under his/her employer's plan may constitute a significant coverage change allowing you to change your Plan coverage level.

### **5.3 Documentation of Eligibility Required to Make Election Change**

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Documentation is required to make an election change, such as birth certificates, passports, evidence of loss of Spouse of Record/Domestic Partner of Record or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Plan 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 for any payments for medical benefits already paid by the Plan.

### **5.4 Deadline to Enroll for Mid-Year Changes**

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If you meet the requirements allowing you to make a mid-year election change, any change made at any time outside of open enrollment period, typically in the fall, you must submit proof of eligibility within 90 days of the change in status event.

If you know you will be adding a Dependent, it is recommended that you pre-enroll your future Dependent by calling the Retiree Service Center. Except for the birth or adoption of a child and court orders, 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. For court orders, the effective date of coverage will be as specified in the court order.

## Section 6. Retiree Premiums and Premium Cap

Retirees who are eligible for UCC coverage and the Company share the cost for Plan coverage and benefits according to the guidelines set forth in this Section 6.

The premium is the cost associated with Plan coverage. The Company pays part of this expense and you pay part of this expense. The portion that the Company 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.

If you are delinquent in paying premiums and you have passed the grace period to pay the premiums, the Plan will allow you to obtain coverage if you pay 102% of the full cost of coverage for the remainder of the Plan Year, plus reimburse the Plan for past due premiums. The Plan reserves the right to require you to pre-pay the premiums in order to receive coverage.

### 6.1 Retiree Medical Budget (Maximum UCC Subsidy, or the "Premium Cap")

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

#### **Premium Cap for Pre-Medicare Eligible Full Service Retirees:**

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

For those who Retire on or after January 1, 2004, a "Full Service" Retiree is a Retiree who has 30 years of Service<sup>5</sup> at the time his or her employment with Union Carbide terminates. A "Full Service" Retiree is also a Retiree who was hired prior to February 6, 2001 who has 85 or more Points. For those who Retired on or after February 1, 1995 and prior to January 1, 2004, a "Full Service" Retiree is a Retiree who had 10 or more years of Service after age 45, or 85 or more points at time of Retirement. For those who Retired prior to February 1, 1995, a "Full Service" Retiree is a Retiree who was at least 50 years old with 10 or more years of Service at time of Retirement.

The Retiree Medical Budget set by UCC for the maximum amount the Company will contribute to premiums for pre-Medicare coverage may be adjusted, up or down, at the Company's sole discretion. Full

<sup>5</sup> "Service" is defined in *Appendix A - Definitions* section of this SPD.

Service Retirees need to be prepared to pay the full amount of the cost of the Program above the premium cap. **In the years after the maximum UCC subsidy is exceeded, your retiree medical premiums will increase significantly.**

**For Retirees Who Are Pre-Medicare Eligible Who Do Not Have Full Service:**

If you are pre-Medicare Retiree who does not have Full Service, then UCC will pay a portion of the amount that UCC pays for Full Service Retirees who are under age 65. For those who Retire on or after January 1, 2004, the portion UCC will pay will be based on the Retiree Medical Support Schedule, subject to the premium cap. (The Retiree Medical Support Schedule applies regardless of whether your employment ended because of lay-off, disability or death.) See the Retiree Medical Support Schedule. For those who Retired prior to January 1, 2004, the portion UCC will pay will be based on the Attribution Schedule, subject to the premium cap. See Attribution Schedule – Pre-Medicare Eligible Retirees. **In the years after the maximum UCC subsidy is exceeded, your retiree medical premiums will increase significantly.**

## 6.2 Retiree Medical Support Schedule

### UCC Retiree Medical Support Schedule- Determines Percent of Full Service Subsidy – Applicable to Those Who Retire On or After January 1, 2004

<u>Years of Service<sup>6</sup> when employment with Union Carbide ends</u>	<u>Your Contribution Towards the Full Service Subsidy</u>	<u>UCC's Contribution Towards the Full Service Subsidy</u>
10	60%	40%
11	57%	43%
12	54%	46%
13	51%	49%
14	48%	52%
15	45%	55%
16	42%	58%
17	39%	61%
18	36%	64%
19	33%	67%
20	30%	70%
21	27%	73%
22	24%	76%
23	21%	79%
24	18%	82%
25	15%	85%
26	13%	87%
27	11%	89%
28	9%	91%
29	7%	93%
30 or more*	0%	100%

This Schedule determines the percentage of UCC's Full Service subsidy that you and UCC will share.

\* Special provisions may apply to certain Retirees who have Service with a company that was acquired by The Dow Chemical Company or UCC or who have service with a subsidiary or a company with whom UCC has entered into a joint venture or other business structure. Retirees with past service with such companies should refer to the Plan Document to see if special terms apply to them.

A Retiree who was hired prior to February 6, 2001, who has 85 or more Points is deemed by the Program to have 30 years of Service; such a Retiree has Full Service. Further, a Retiree who Retired on or after February 1, 1995 and prior to January 1, 2004, and who had 10 or more years of Service after age 45, or 85 or more Points at time of Retirement is deemed by the Program to have 30 years of Service; such a Retiree has Full Service. A Retiree who Retired prior to February 1, 1995 has Full Service if he was at least 50 years old with 10 or more years of Service at time of Retirement.

<sup>6</sup> "Service" is defined in *Appendix A - Definitions* section of this SPD.

**Attribution Schedule<sup>7</sup> – Pre-Medicare Retirees (applicable to those who Retired prior to January 1, 2004 with less than 85 Points or fewer than 10 years of service after age 45)**

Years of Service after age 45	1-5	6	7	8	9	10
% of Full Service Subsidy Paid by UCC	14	24	39	54	69	100

\*Same premium as for Full Service Retiree.

**Attribution Schedule<sup>8</sup> – Medicare Eligible Retirees (Applicable to Those Who Retired Prior to January 1, 2004 with less than 85 Points or fewer than 10 years of service after age 45)**

Years of Service after age 45	1-5	6	7	8	9	10
% of Full Service Subsidy Paid by UCC	0	10	20	30	40	50

**60 Point Retiree Medical Severance Plan Participants**

If you are a 60 Point Retiree Medical Severance Plan Participant, you will be subject to the premium caps described above. If your employment was terminated prior to January 1, 2004, and you do not have Full Service, your premium will be calculated according to the applicable Attribution Schedule or the Retiree Medical Support Schedule, whichever provides you the greater Union Carbide subsidy. If your employment was terminated on or after January 1, 2004, your premium will be determined according to the Retiree Medical Support Schedule.

**Special Rule for Retirees Who’s Employment was Involuntarily Terminated between 8/1/03 and 1/1/04**

If you are not a 60 Point Retiree Medical Severance Plan Participant, but are a Retiree whose employment with a Participating Employer was involuntarily terminated after August 1, 2003 but before January 1, 2004 and:

1. you received a payment from the UCC U.S. Severance Plan, and
2. you do not have Full Service

then your premium will be calculated as if you have Full Service. You will be subject to the premium cap.

<sup>7</sup> The Attribution Schedule does not apply to Employees who Retired prior to January 1, 2004 due to lay-off, disability or death. Such Retirees are deemed to have Full Service.

<sup>8</sup> The Attribution Schedule does not apply to Employees who Retired prior to January 1, 2004 due to lay-off, disability or death. Such Retirees are deemed to have Full Service.

## **6.3 Long Term Disability Participants and Disability Retirees Under Union Carbide Employees' Pension Plan**

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If you are an Employee who is approved to receive a benefit under and is “totally and permanently disabled” as defined in The Dow Chemical Company Long Term Disability Income Protection Plan or the Union Carbide Employees' Pension Plan, see Section 3.3.

## **6.4 Excess Premium Payments**

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

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.

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 Administrator 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 7. Survivor Benefits

### 7.1 Surviving Spouse/Domestic Partner of Deceased Active Employees

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In general, surviving Spouses/Domestic Partners whose Spouse died while actively employed at UCC are offered coverage through the UCC Retiree Medical Care Program. A surviving Spouse/Domestic Partner does not need to be enrolled at the time of death to be eligible. However, depending on whether he is covered under another health plan, he may be restricted in which UCC Plan he may enroll in. Eligibility and plan provisions for Surviving Spouses/Surviving Domestic Partners of deceased active Employees are the same as for Spouses of Record/Domestic Partners of Record of deceased Retirees and deceased 60 Point Retiree Medical Severance Plan Participants; except that Surviving Spouses/Surviving Domestic Partners under the age of 50 whose Spouse died while actively employed at UCC pay active rates until the first day of the month following the Surviving Spouse's/Surviving Domestic Partner's 50<sup>th</sup> birth date. At age 50, the Retiree Support Schedule applies and the Surviving Spouse/Domestic Partner is deemed to have Full Service. If the deceased Employee was ineligible for coverage once he became Medicare-eligible, the Surviving Spouse/Surviving Domestic Partner is ineligible for coverage when such survivor is Medicare-eligible. In such a situation, if the deceased and the Surviving Spouse/Surviving Domestic Partner were not eligible for Medicare at the time of death, then the Surviving Spouse/Surviving Domestic Partner is required to pay 102% of the full cost to insure from the date the deceased would have become Medicare-eligible until the Spouse/Domestic Partner becomes Medicare eligible. A Surviving Spouse/Surviving Domestic Partner who is eligible for coverage another group medical plan, either as a retiree or a full time employee, must be enrolled in that plan to continue coverage under the Program. If your Surviving Spouse/Surviving Domestic Partner is enrolled for coverage under the Program, your surviving Dependent children may also be covered as long as they meet eligibility requirements. In order to be eligible for coverage, your surviving Dependent children must be enrolled in any group medical coverage available from your Surviving Spouse's/Surviving Domestic Partner's employer or business. Such Dependent children will be subject to the corresponding premium rate.

### 7.2 Surviving Spouses of Record/Surviving Domestic Partners of Record of Deceased Retirees and Deceased 60 Point Retiree Medical Severance Plan Participants

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In general, Surviving Spouses of Record/Domestic Partners of Record of deceased Retirees (including deceased Disability Retirees) and deceased 60 Point Retiree Medical Severance Plan Participants are eligible to continue coverage under UCC Retiree Medical Care Program. Such a Surviving Spouse of Record/Domestic Partner of Record does not need to be enrolled at the time of death to be eligible. However, depending on whether he is covered under another health plan, he may be restricted in which UCC Plan he may enroll in. If your Surviving Spouse of Record/Domestic Partner of Record is employed full time or is a retiree, and your Spouse of Record's/Domestic Partner of Record's employer offers medical coverage, your Surviving Spouse of Record/Domestic Partner of Record must be enrolled in that plan in order to obtain coverage under the UCC plan. The same applies if your Spouse of Record/Domestic Partner of Record is the owner or business partner of a business that offers medical coverage. Eligibility for Surviving Spouses of Record/Domestic Partners of Record is the same as the deceased Employee or Retiree (or 60 Point Retiree Medical Severance Plan Participant) with respect to post-Medicare eligibility. If the deceased Retiree (or 60 Point Retiree Medical Severance Plan Participant) was ineligible for UCC coverage because he was Medicare eligible, the Surviving Spouse of Record/Domestic Partner of Record is ineligible for coverage if such survivor is Medicare eligible. Currently, UCC pays the full cost to insure for Surviving Spouses of Record/Domestic Partners of Record of deceased Disability Retirees whose disability retirement was approved prior to January 1, 2006. For all other Survivors described in this paragraph, the Retiree Medical Support Schedule and Retiree Medical Budget applies to determine the applicable premium the Survivor must pay for coverage.

## **7.3 Surviving Spouses of Record/Surviving Domestic Partners of Record of Deceased LTD Plan Participants**

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If the date of “full disability” (as defined under LTD) of the deceased is prior to January 1, 2006, and the deceased is approved for LTD benefit payments, the Surviving Spouse of Record/Surviving Domestic Partner of Record currently is not required to pay a premium for coverage.

If the date of “full disability” (as defined under LTD) of the deceased is on or after January 1, 2006, and the deceased is approved for LTD benefit payments, and the deceased had ten (10) or more years of Service as of the effective date of LTD benefit payments, the Surviving Spouse of Record/Surviving Domestic Partner or Record is subject to the same rules applicable to Survivors of active Employee deaths.

If the date of “full disability” (as defined under LTD) of the deceased is on or after January 1, 2006, and the deceased is approved for LTD benefit payments, and the deceased had less than one (1) year of Service as of the effective date of LTD benefit payments, the Surviving Spouse of Record/Surviving Domestic Partner or Record may continue coverage for the remainder of the 12 month period that was available to the deceased by paying the same premiums active employees pay for comparable coverage.

If the date of “full disability” (as defined under LTD) of the deceased is on or after January 1, 2006, and the deceased is approved for LTD benefit payments, and the deceased had one (1) year of Service, but less than ten (ten) years of Service, as of the effective date of LTD benefit payments, the Surviving Spouse of Record/Surviving Domestic Partner or Record may continue coverage for the remainder of the 24 month period that was available to the deceased by paying the same premiums active employees pay for comparable coverage.

## **7.4 Surviving Child(ren)**

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If your Surviving Spouse of Record/Domestic Partner of Record is enrolled for coverage under the Program, your surviving Dependent Child(ren), including your biological child in utero, also may be covered under the corresponding rates applicable. They must meet the Dependent eligibility requirements. If your Surviving Spouse of Record/Domestic Partner of Record works full time, he/she must enroll your children in any group medical coverage offered by his/her Surviving Spouse of Record/Domestic Partner of Record’s employer.

If there is no Surviving Spouse of Record/Domestic Partner of Record, your surviving child(ren) who were eligible for coverage at the time of your death will be able to receive continued coverage for up to 36 months. This coverage meets the requirements of, and runs concurrently with, the coverage required under the Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”). UCC will subsidize the COBRA premiums for the first 12 months. Your surviving Dependent Child(ren) will be eligible for coverage under the Program with premiums applicable to Retirees for up to one year after the date of your death. They must complete an enrollment form and pay the applicable premiums within the time specified by the Plan Administrator. Thereafter, if they were covered for the first 12 months and paid the required premiums they will be offered the remaining 24 months of coverage at COBRA rates 102% of the full cost to insure. Again, in order to be covered, they must elect coverage and pay the required premiums within the time periods specified by the Plan Administrator.

## **7.5 Remarriage of a Surviving Spouse of Record/Domestic Partner of Record**

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A Surviving Spouse of Record/Domestic Partner of Record may not cover their new Spouse/Domestic Partner under the Program.

## Section 8. HIPAA and Other Laws

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborn's and Mother's Health Protection Act of 1996, and other federal legislation require the following:

#### Women's Health and Cancer Rights Act of 1998

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

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

#### Maternity Stays

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

#### Certificates of Coverage:

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

You are required to inform Dow of any change in your Dependent's eligibility status as soon as possible, and no later than during the annual *Choices* enrollment. 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 9. Information Provided by Plan to Third Parties

### 9.1 Information Exchanged by the Program's Business Associates

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The Company and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates. Aggregate data and summary health information, as defined by HIPAA, may be used by the Plan Sponsor to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with the Company and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA. A copy of the Plan's Notice of Privacy Practices is attached as Appendix B of this SPD.

## Section 10. Filing a Claim

### 10.1 Filing Claims for Benefits and Appealing Claims Denials

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If you want to file or appeal a denial of a *Claim for an Eligibility Determination*, see *Section 26* of this SPD. If you want to file or appeal a denial of a *Claim for Plan Benefits*, see the Self-Funded HMO Administrator's claims procedures described in the *Description of Plan Benefits* (Appendix A) of this SPD).

A *Claim for an Eligibility Determination* is a Claim requesting a determination as to whether a claimant is eligible to be a Participant under a Self-Funded HMO Plan.

A *Claim for Plan Benefits* is a Claim requesting that the Self-Funded HMO Plan pay for benefits covered under the Self-Funded HMO Plan.

## Section 11. Fraud Against the Program

### 11.1 Fraud Against the Program

Any Participant who intentionally misrepresents information to the Program or knowingly misinforms, deceives, or misleads the Program, 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 Program for Claims paid by the Program. The Program may choose to pursue civil and/or criminal action. The Plan Administrator may determine that such Participant (who could be the Retiree) and the covered Dependents are no longer eligible to participate in the Program because of the Participant's actions. In addition if the Participant (who could be the Retiree) and the covered Dependents are terminated from eligibility under any benefit plan sponsored by Union Carbide Corporation or any of its subsidiaries or affiliates because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that the Participant (who could be the Employee or Retiree) and all Dependents are not eligible for coverage under the Program.

## Section 12. Ending Coverage

### 12.1 When Coverage Ends

Coverage ends when any of the following occurs:

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

When your Dependent is no longer eligible, or dies, complete the applicable enrollment form which can be obtained from the Retiree Service Center at (800) 344-0661 or (989) 636-0977, within 90 days of the loss of eligibility. You may qualify for a reduction in your monthly premium. If you qualify for a reduction in premium, the premium will be reduced effective the date you complete the enrollment form or 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.**

### 12.2 COBRA Continuation Coverage

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

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

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:

Ceridian COBRA Continuation Services National Service Center  
3201 34<sup>th</sup> Street South  
St. Petersburg, Florida 33711-3828  
1(800) 877-7994

## 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 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 Spouse of Record 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 Retiree Service Center. In addition, you must complete and submit the forms described below within the time required. See telephone numbers listed above for the Plan Administrator. Written notice is required for divorce. If you are providing written notice, you must send this notice to the Plan Administrator at the address above. In addition, if the qualifying event is divorce, you must provide the Plan Administrator within 60 days of the qualifying event:

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

If the qualifying event is a Dependent child's loss of eligibility for coverage under a Program, you must notify the Retiree Service Center. 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 60<sup>th</sup> 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 Record 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 Record 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 Record 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 those 45 days, you will lose all continuation coverage rights of the Program.**

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

## Section 13. The Program's Subrogation Right and Right of Recovery

As used in this Section 13, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes the liability insurer of such party or any Insurance Coverage.

For purposes of this Section 13, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

### **Subrogation**

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

### **Reimbursement**

If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Program has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Program has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

### **Constructive Trust**

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

### **Lien Rights**

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

### **First-Priority Claim**

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person acknowledges that the Program's recovery rights are a first priority claim against all Third Parties and are to be paid to the Program before any other claim for the Covered Person's damages. The Program is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, *even if such payment to the Program will result in a recovery to the Covered Person that is insufficient to make him or her whole.*

**Applicability to All Settlements and Judgments**

The Program is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Program provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Program is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

**Program Not Required to Pay Court Costs or Attorneys Fees**

The Program is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

**Your Responsibilities**

The Covered Person is required to fully cooperate with the Program's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Program, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Program may reasonably request. The Covered Person shall do nothing to prejudice the Program's subrogation or recovery interest or to prejudice the Program's ability to enforce the terms of the Program's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program.

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

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

The Covered Person's obligation to reimburse the Program is limited to the amount of medical benefits the Program has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. In no event will the Covered Person be required to reimburse the Program in any amount exceeding the amount received from the Responsible Party.

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

**Jurisdiction**

For purposes of this Section 13, by accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Program, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Program may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

## Section 14. Grievance Procedure

If you want to appeal the denial of a Claim for an Eligibility Determination, see *Claims Procedures* section of this SPD. If you want to appeal the denial of a Claim for Plan Benefits, see the *Description of Benefit* (Appendix A) of this SPD.

If you feel that anyone is discriminating against you for exercising your rights under the Program, or someone has interfered with the attainment of any right to which you feel you are entitled under the Program, or if you feel that the Plan Administrator has denied you any right you feel that you have under the Program, you can file a grievance with the Plan Administrator. You must notify the Plan Administrator listed in the *ERISA Information* section of this SPD in writing within 120 days of the date of the alleged wrongdoing. The Plan Administrator will investigate the allegation and respond to you in writing within 120 days.

If the Plan Administrator determines that your allegation has merit, the Plan Administrator will either correct the wrong, if it was the Program that did the wrong, or will make a recommendation to the Plan Sponsor or Participating Employer if any of them have been alleged to be responsible for the wrongdoing. If the Plan Administrator determines that your allegation is without merit, you may appeal the Plan Administrator's decision. You must submit written notice of your appeal to the Plan Administrator within 60 days of receipt of the Plan Administrator's decision. Your appeal will be reviewed and you will receive a written response within 60 days, unless special circumstances require an extension of time. The Plan Administrator will give you written notice and reason for the extension. In no event should the decision take longer than 120 days after receipt of your appeal.

The decisions of the Plan Administrator shall be final and binding. If you are not satisfied with the Plan Administrator's response to your appeal, you may file suit in court. If you file a lawsuit, you must do so within 120 days from the date of the Plan Administrator's written response to your appeal. Failure to file a lawsuit within the 120 day period will result in your waiver of your right to file a lawsuit.

## Section 15. Your Legal 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, the Plan Document, other documents governing the Program, and the latest annual report filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of the Plan Document and *Summary Plan Descriptions*. The Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Program's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. Continue health care coverage for yourself, Spouse of Record or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents must pay for such coverage. Review this SPD's *COBRA Continuation Coverage* section for more information.

In addition to creating rights for you and all other Program Participants, ERISA imposes duties on the people who are responsible for operating an employee benefit plan. The people who operate the Program are called "fiduciaries", have a duty to act prudently and in the interest of you and other Participants and beneficiaries. If it should happen that fiduciaries misuse any of the Program's money, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. **Under the terms of this Program, if you file a lawsuit, you must do so within 120 days from the date of the alleged**

**misuse. Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit.**

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 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.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a Program benefit, or from exercising your rights under ERISA. If you feel that anyone is discriminating against you for exercising your rights under this Program, or if you feel that someone has interfered with the attainment of any right to which you feel you are entitled under this Program, you must notify the Plan Administrator listed in the *ERISA Information* section of this SPD in writing within 120 days of the date of the alleged wrongdoing. The Plan Administrator will investigate the allegation and respond to you in writing within 120 days. If the Plan Administrator determines that your allegation has merit, the Plan Administrator will either correct the wrong, if it was the Program which did the wrong, or will make a recommendation to the Plan Sponsor or Participating Employer if any of them have been alleged to be responsible for the wrongdoing. If the Plan Administrator determines that your allegation is without merit, you may appeal the Plan Administrator's decision. You must submit written notice of your appeal to the Plan Administrator within 60 days of receipt of the Plan Administrator's decision. Your appeal will be reviewed and you will receive a written response within 60 days. If you are not satisfied with the Plan Administrator's response to your appeal, 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 Plan Administrator's written response to your appeal. Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit.**

If you have any questions about the information in this SPD or an eligibility for coverage question, you should contact the Plan Administrator. If you have a question about the benefits covered, or the terms and conditions for receiving benefits, network providers, etc., you should contact the the applicable Self-Funded HMO Plan administrator listed in the ERISA Information section of this SPD. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration at (800) 998-7542.

## Section 16. 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 26 for information about the Claims Administrator's discretion.

## Section 17. Welfare Benefits

Welfare benefits, such as the Self-Funded HMO Plans, are not required to be guaranteed by a government agency.

## Section 18. The Company's Right to Terminate or Amend the Program

The Company reserves the right to amend, modify or terminate Union Carbide Corporation Retiree Medical Care Program (and/or 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.

## Section 19. Disposition of Plan Assets If the Program Is Terminated

The Company may terminate the Union Carbide Corporation Retiree Medical Care Program at any time at its sole discretion. If the Company terminates the Program, the assets of the Program, if any, shall not be used for the benefit of the Company, but may be used to:

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

## Section 20. Class Action Lawsuits

Legal actions against the Plan must be filed in U.S. federal court. Class action lawsuits must be filed either 1) in the jurisdiction in which the Plan is administered (Michigan) or 2) the jurisdiction in the

United States of America where the largest number of putative members of the class action reside. This provision does not waive the requirement to exhaust administrative remedies before the filing of a lawsuit.

## Section 21. Rebates and Other Money Received by the Plan

Occasionally, the Program receives money from rebates from prescription drug manufacturers or providers of medical services, or proceeds from class action lawsuits or settlements, or from providers from quality improvement programs, incentive compensation arrangements, risk-based compensation (including but not limited to withholds, bonuses, incentive payments, provider credits or member management fees). The amounts that the Program receives are usually small in comparison to the total claims costs and administrative expenses for the Program. The Plan Administrator may use the money it receives in these situations to pay claims and administrative expenses of the Program.

## Section 22. Funding

The Company shares the premium costs with the Participants. The Company's contribution to the premiums is limited to the retiree medical budget established in January 2000, and July 2003. The Company's retiree medical budget is described in the *Premiums and Premium Cap* section of this SPD. Benefits are paid from the Company's general assets, and at the Company's discretion, a special retiree medical account within the trust for the Union Carbide Employees' Pension Plan. Participant contributions will be used in their entirety to pay benefits prior to using the Company contributions to pay benefits. Any assets of the Program may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program may be amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys fees, third party administrator fees and other administrative expenses.

## Section 23. Uncashed Checks

Uncashed checks for the payment of benefits shall not escheat to the state, but shall remain in the Company's general assets. The Plan Administrator is entitled to rely on the last address provided to the Program by the Participant and have no obligation to search for or ascertain a Participant's whereabouts. If the Plan Administrator determines that there are no extenuating circumstances, after one (1) year of the date of the check, the Program's obligation to pay the benefit underlying the uncashed check is extinguished.

## Section 24. Payment of Unauthorized Benefits

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

- The amount of any other benefit paid to such Participant, Dependent or other person under the Program shall be reduced by the amount of the excess payment; and/or
- The Plan Administrator may require the Participant, Dependent or other person to reimburse the Program; and or
- The Plan Administrator may elect recoupment or reimbursement regardless of whether the person who received the excess benefit was a Participant or Dependent entitled to receive benefits under the Program, and regardless of whether the excess benefit was provided by reason of the Administrator's error or by reason of false misleading, or inaccurate information furnished by the Participant or Dependent or any other person.

## Section 25. Definitions of Terms

The following are some of the defined terms of the Self-Funded HMO Plans. Additional terms are defined in the Plan Document for the Program and the Description of Plan Benefits (Appendix A of this SPD). 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.

**60 Point Retiree Medical Severance Plan Participant:**

Refers to a "60 Point Retiree Medical Severance Plan Participant" as defined in the Plan Document.

**60 Point Severance Plan Participant:**

Refers to a "60 Point Retiree Medical Severance Plan Participant" as defined in the Plan Document.

**60 Point Retiree Medical Participant:**

Refers to a "60 Point Retiree Medical Severance Plan Participant" as that term is defined in the Plan Document.

**Affiliate:**

An entity that is 49% or more-owned, directly or indirectly, by The Dow Chemical Company.

**Appeals Administrator:**

The Appeals Administrator with respect to reviewing an adverse Claim for Benefit is the applicable Self-Funded HMO administrator listed in the ERISA Information section of this SPD (i.e., Blue Care, Blue Cross, CIGNA, HealthPartners or Humana). The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the Global Director of Benefits for The Dow Chemical Company.

**Bargained-for Individual or Bargained-for Employee:**

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

**Blue Care:**

Blue Care Network. Contact information is listed in the *ERISA Information* section of this SPD.

**Blue Cross or Blue Cross /Blue Shield:**

Blue Cross/Blue Shield of Michigan . Contact information is listed in the *ERISA Information* section of this SPD.

**CIGNA or CG:**

CIGNA Health Care or Connecticut General Life Insurance Company. Contact information is listed in the *ERISA Information* section of this SPD.

**Claim:**

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

**Claim for Eligibility Determination:**

A Claim requesting a determination as to whether a claimant is eligible to be a Participant under the Plan or Program. 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 federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) that allows a Member to stay enrolled in the Program for a limited time after coverage for that person would ordinarily cease.

**Company:**

Union Carbide Corporation.

**Covered Person or Member:**

An Employee, Retiree, 60 Point Retiree Medical Severance Plan Participant, LTD Participant, Survivor, a Dependent child who has coverage under the Plan, or a person who is continuing coverage under COBRA.

**Creditable Coverage:**

Coverage under either of the Programs, Medicare, Medicaid, or any other group health, individual health or other health insurance coverage described in 29 CFR s. 2590.701-4.

**Credited Service:**

Credited service recognized under the Union Carbide Employees’ Pension Plan.

**Dependent:**

A Retiree’s Spouse of Record or Domestic Partner of Record, or a Dependent child (as defined below).

**Dependent child:**

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

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

in a court of law. "Legally relinquished all of their parental rights," means that the biological parents permanently do not have the:

- authority to consent to the child's Marriage or adoption, or
- authority to enlist the child in the armed forces of the U.S.;
- right to the child's services and earnings; and
- power to represent the child in legal actions and make other decisions of substantial legal significance concerning the child, including the right to establish the child's primary residence.

In addition to meeting the above requirements, in order to be 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 26<sup>th</sup> birthday, may continue coverage.

**Domestic Partner of Record:**

For Retirees (and 60 Point Retiree Medical Severance Plan Participants and LTD Participants) who were 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 Union Carbide Corporation Retiree Medical Care Program on December 31, 2002, and continues to be the former Employee's Domestic Partner. In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to December 31, 2002.

For Retirees (and 60 Point Retiree Medical Severance Plan Participants and LTD Participants) who became 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 Medical Care Program on the former Employee's last day on the payroll, and continues to be the former Employee's Domestic Partner. In order for a Domestic Partner to be eligible for Domestic Partner benefits, a statement of Domestic Partnership satisfactory to the Plan Administrator must have been submitted on or prior to the Employee's last day on the payroll.

References to "Domestic Partner of Record" are applicable to Retirees, 60 Point Retiree Medical Severance Plan Participants, and LTD Participants. The term, "Domestic Partner of Record", does not apply to active Employees, except with respect to an active Employee who dies. In such case, "Domestic Partner of Record" is the Domestic Partner of such active Employee as of the date of the active Employee's death.

**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
2. each of the two people have signed a statement acceptable to the Plan Administrator and have provided it to the Plan Administrator.

**Dow:**

When used in this *SPD*, Dow refers to The Dow Chemical Company.

**Eligibility Determination Claims:**

Claims requesting a determination as to whether a claimant is eligible to be a Participant under the Plan or Program.

**Eligibility Service:**

Eligibility service recognized under the Union Carbide Corporation Employees' Pension Plan.

**Employee:**

A person who:

- is employed by a Participating Employer to perform personal Services in an employer-Employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute; and
  - receives a payment for Services performed for the Participating Employer directly from a Participating Employer's U.S. Payroll Department, and
  - is either a Salaried individual who is classified by the Participating Employer as having regular Full-Time status, a Salaried individual who is classified by the Participating Employer as having active Less-Than-Full-Time active status, or is a Bargained-for Individual who is classified by the Participating Employer as having regular Full-Time active status; and
  - if Localized, is Localized in the U.S.; and
  - if on international assignment, is a U.S. citizen or Localized in the U.S.
- The definition of "Employee" does not include an individual who performs Services for the benefit of a Participating Employer if his compensation is paid by an entity or source other than the Participating Employer's U.S. Payroll Department. Further, the definition of "Employee" does not include any individual who is characterized by the Participating Employer as an independent contractor, contingent worker, consultant or contractor. These individuals are not "Employees" (with a capital "E") for purposes of the Plan even if such individual(s) is determined by a court or regulatory agency to be a "common law employee" of a Participating Employer.

**Family:**

The lives covered under the Employee, Retiree, Surviving Spouse/Domestic Partner (of a deceased active Employee), Surviving Spouse of Record/Surviving Domestic Partner of Record (of a deceased Retiree), 60 Point Retiree Medical Severance Plan Participant, or LTD Participant who is enrolled in the Plan.

**Full Service:**

For those who Retire on or after January 1, 2004, a "Full Service" Retiree is a Retiree who has 30 years of Service at the time his or her employment with Union Carbide terminates. A "Full Service" Retiree is also a Retiree who was hired prior to February 6, 2001 who has 85 or more Points. For those who Retired on or after February 1, 1995 and prior to January 1, 2004, a "Full Service" Retiree is a Retiree who had 10 or more years of Service after age 45, or 85 or more Points at time of Retirement. For those who Retired prior to February 1, 1995, a "Full Service" Retiree is a Retiree who was at least 50 years old with 10 or more years of Service at the time of Retirement.

For 60 Point Retiree Medical Severance Plan Participants:

- "Full Service" means a former Employee who has 30 or more years of Service at the time his or her employment with Union Carbide terminates.

- If a former Employee was hired prior to February 6, 2001, and has 85 or more Points, the former Employee also has “Full Service”.
- If the former Employee’s employment was terminated on or after August 1, 2003 and prior to January 1, 2004, and he has 10 or more years of Service after age 45, or 85 or more Points at time of termination of employment, the former Employee also has “Full Service”.

**Full-Time:**

An Employee classified by the Participating Employer as having Full-Time status.

**HealthPartners” or “HPAI:**

HealthPartners Administrators Inc.. Contact information is listed in the *ERISA Information* section of this SPD.

**Highly Compensated Employee:**

Any person who is a “highly compensated employee” as such term is defined in section 414 (q) of the U.S. Internal Revenue Code.

**HIPAA:**

The Health Insurance Portability and Accountability Act.

**HMO:**

Health Maintenance Organization.

**Hourly Employee:**

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

**Humana :**

Humana Insurance Company. Contact information is listed in the *ERISA Information* section of this SPD.

**Initial Claims Reviewer:**

The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the applicable Self-Funded HMO administrator listed in the ERISA Information section of this SPD (i.e., Blue Care, Blue Cross, CIGNA, HealthPartners or Humana).. The Initial Claims Reviewer with respect to deciding a Claim for an Eligibility Determination is the U.S. Health and Welfare Leader.

**Less-Than-Full-Time:**

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

**Localized:**

A person is “Localized” when a Participating Employer has made a determination that an Employee is permanently relocated to a particular country, and the Employee has accepted such determination. For example, a Malaysian national is “Localized” to the U.S. when a Participating Employer has determined that such Employee is permanently relocated to the U.S., and such Employee has accepted such determination.

**LTD Participant:**

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

**Marriage:**

A civil contract between a man and a woman. The man and woman must have the legal capacity to marry, and the contract must have been formalized by a marriage license with formalities similar to and consistent with the requirements for a valid marriage in the state of Michigan. The Plan does not recognize common law marriages except that: (a) if an Employee or Retiree was a participant in a medical plan sponsored by

UCC any time between February 5, 2001 and December 31, 2001, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a medical plan sponsored by UCC any time between February 5, 2001 and December 31, 2001, then such common law Spouse is deemed under the Program to be Married to the Retiree; and (b) the Plan recognizes a marriage that meets the requirement of Texas Family Code Annotated s. 1.91(a)(1)

**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.

**Medicare Modernization Act:**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**Medicare Part D:**

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

**Medicare prescription drug plan:**

A prescription drug plan that has been approved as specified in 45 CFR s. 423,272. These prescription drug plans meet the minimum standards set forth by the Medicare Modernization Act. As referred to in this SPD, Medicare Part D does not refer to Medicare Advantage HMO plans that provide prescription drug coverage.

**Participant:**

A Retiree, Survivor, 60 Point Retiree Medical Severance Plan Participant, , or LTD Participant who participates in the Program because he meets the eligibility criteria of the Program.

**Participating Employer:**

Union Carbide Corporation or one of its subsidiaries that has been authorized by Union Carbide Corporation to participate in the Program. “Participating Employers” and “Union Carbide” have the same meaning and are used interchangeably.

**Plan:**

The Self-Funded HMO Plans, which are components of the Union Carbide Corporation Retiree Medical Care Program.

**Program:**

The Union Carbide Corporation Retiree Medical Care Program.

**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 the *ERISA* Section of this *SPD*).

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

**Retiree:**

A "Retiree" is defined as:

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

was age 48 or older with at least eight (8) years of service or age 60 or older with at least 8 years of service at the time his employment was involuntarily terminated by action of a Participating Employer and commenced a benefit under the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries at the time of termination of employment, or

was age 47 or older with at least seven (7) years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under a severance program sponsored by the Company

- Until and through February 5, 2003, for individuals who were employed by the Company prior to February 6, 2001, and became "retirees" under the Union Carbide Employees' Pension Plan (as "retiree" is defined under that retirement program) on or after February 6, 2001, a Retiree also includes a former Employee who:

was age 47 or older with at least seven (7) years of service at the time his employment was involuntarily terminated by action of a Participating Employer and signed a release under the Union Carbide Corporation Special Severance Protection Program.

For individuals who terminate employment after February 6, 2001, a Retiree means a former Employee who:

1. was age 50 or older with at least 10 years of Service at the time his employment terminated with a Participating Employer, who is also a "retiree" under the terms of Union Carbide Employees' Pension Plan; or
2. has been Localized in the U.S. and:
  - a. is still a Localized U.S. Employee when his employment with a Participating Employer ends, and
  - b. is age 50 or older with 10 or more years of Service and his employment with a Participating Employer ends, and
  - c. at the time he was Localized in the U.S., he was eligible for Union Carbide Employees' Pension Plan, although he need not participate in Union Carbide Employees' Pension Plan or be vested in Union Carbide Employees' Pension Plan at the time his employment ends, and
  - d. at the time his employment with the Participating Employer ends, he is not immediately transferred to an 80% or more owned Dow subsidiary or affiliate.

An Employee who was at least age 50 or older with 10 or more years of Service at the time employment with the Participating Employer ends, and whose pension assets in the Union Carbide Employees' Pension Plan were transferred to a pension plan of an entity that is not a Participating Employer is not considered

“retired” under the terms of the Union Carbide Employees’ Pension Plan. Such former Employee does not meet the Program’s definition of “Retiree”.

**Retiree Medical Budget:**

The maximum amount that Union Carbide Corporation may subsidize retiree medical premiums. UCC may choose to subsidize retiree medical premiums below the Retiree Medical Budget.

**Retiree Medical Participant:**

This term is used in the context of explaining the Retiree Medical Budget in the *Premiums and Premium Cap* section of this SPD. It means a participant who is either a Retiree, 60 Point Retiree Medical Severance Plan Participant, an LTD Participant, or a Survivor under either the HMO or Triple S components of the Union Carbide Corporation Insured Health Program or the Union Carbide Corporation Retiree Medical Care Program, as those terms are defined in those programs, respectively.

**RHCAP**

The Dow Chemical Company Retirement Health Care Assistance Plan.

**Salaried Individual:**

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

**Self-Funded HMO Plans:**

Self-Funded HMO Plans are plans that have the same or similar plan design as an HMO, but are funded from UCC’s general assets. The HMO administers the Self-Funded HMO Plan under a contract with Dow or UCC. Self-Funded HMO Plans “look” and “feel” like HMOs in most respects, except that the medical expenses are paid from Dow’s or UCC’s general assets instead of the HMO’s. The Self-Funded HMO Plans described in this SPD are:

- Blue Care Network Self-Funded HMO
- Blue Cross /Blue Shield of Michigan (Illinois) Self Funded HMO
- CIGNA Self Funded HMO
- HealthPartners Self Funded HMO
- Humana Self Funded HMO

**Service:**

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

- a. Except as otherwise provided in the next sentence, with respect to a former Employee who was hired on or after February 6, 2001, but prior to January 1, 2008, by a subsidiary or affiliate of the Company or The Dow Chemical Company that was 80% or more owned by the Company or The Dow Chemical Company at the time such Employee was hired by such subsidiary or affiliate, “Service” shall mean Credited Service. Only Service prior to January 1, 2010 will be recognized by the Program for Employees working for the Dow Mid-Michigan Business Process Service Center.
- b. Except as otherwise provided in the next sentence, with respect to a former Employee of an entity acquired by the Company or The Dow Chemical Company on or after February 6, 2001, but prior to January 1, 2008, the Program deems the later of the date the entity became a Participating Employer under the Program, or the employee’s hire date at such entity, as the date of hire for purposes of determining whether an Employee was hired before or after February 6, 2001. Only Service prior to January 1, 2010 will be recognized by the Program for Employees working for the Dow Mid-Michigan Business Process Service Center.
- c. With respect to former Employee of an entity acquired by the Company or The Dow Chemical Company on or after February 6, 2001, but prior to January 1, 2008, which entity does not become a Participating Employer under the Program, who subsequently is hired by the Company, the hire date shall be the date the Company hired such Employee for purposes of determining whether an Employee was hired before or after February 6, 2001.

- d. With respect to a former Employee who is rehired and is a participant in the UCEPP component of the Union Carbide Employees' Pension Plan on the date of re-hire, the Program will recognize your first hire-date to determine whether eligibility or credited service (as recognized by the Union Carbide Employees' Pension Plan) is applicable, and to determine how much Service will be recognized by the Program.
- e. With respect to a former Employee who is rehired and is NOT a participant of the UCEPP component of the Union Carbide Employees' Pension Plan on the date of re-hire, the Program will recognize your first hire-date to determine whether eligibility or credited service (as recognized by the Union Carbide Employees' Pension Plan ) is applicable, and to determine how much Service will be recognized by the Program, provided; 1) on the date you terminated employment with Union Carbide, you were eligible for coverage under the Program as a Retiree, 60 Point Retiree Medical Severance Plan Participant, 2) you were subsequently rehired by Union Carbide, and 3) after rehire, you became a participant in the Personal Pension Account component of the Union Carbide Employees' Pension Plan.

With respect to Retirees who have been Localized in the U.S., and only for purposes of determining eligibility, "Service" means the period(s) of time that the Retiree worked for the Company or any affiliate or subsidiary, if during the period the Retiree worked for such affiliate or subsidiary, the Company or the Company's parent owned 80% or more of such affiliate or subsidiary. For purposes of the Retiree Support Schedule, "Service" shall only include the period(s) of time that the Retiree worked for the Company or any affiliate or subsidiary, if during the period the Retiree worked for such affiliate or subsidiary, the Company or the Company's parent owned 50% or more of such subsidiary or affiliate; and either such subsidiary or affiliate subsidized retiree medical coverage for its employees in an amount comparable to the Company's subsidization of the Program, or such subsidiary or affiliate was located in a country whose government provides coverage comparable to the Program's coverage to such subsidiary or affiliate's retirees. Further, with respect to Retirees who have been Localized in the U.S., for purposes of determining whether the hire date was before or after February 6, 2001, the Program will only recognize hire dates and periods of employment with subsidiaries and affiliates that provide subsidized retiree medical coverage for their employees in an amount comparable to the Company's subsidization of the Program, and with subsidiaries and affiliates that are located in countries whose governments provide coverage to such subsidiaries and affiliate's retirees comparable to the Program's coverage.

**Significant Break In Coverage:**

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

**Spouse of Record:**

For Retirees (and 60 Point Retiree Medical Severance Plan Participants and LTD Participants) who were eligible for coverage under the Program prior to January 1, 2003, "Spouse of Record" means the person who was Married to the former Employee on December 31, 2002, and continues to be Married to the former Employee.

For Retirees (and 60 Point Retiree Medical Severance Plan Participants and LTD Participants) 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 former Employee on his or her last day on the payroll, and continues to be Married to the former Employee.

References to "Spouse of Record" are applicable to Retirees, 60 Point Retiree Medical Severance Plan Participants, and LTD Participants. The term, "Spouse of Record", does not apply to active Employees, except with respect to an active Employee who dies. In such case, "Spouse of Record" is the Spouse of such active Employee as of the date of the active Employee's death.

**Spouse of Record/Domestic Partner of Record:**

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

**Summary Plan Description (“SPD”):**

The summary plan description for the Self-Funded HMO Plans, including appendices.

**Surviving Spouse of Record or Surviving Domestic Partner of Record:**

The widowed Dependent Spouse of Record/Domestic Partner of Record of a Retiree or 60 Point Retiree Medical Severance Plan Participant or LTD Participant who was eligible to participate in the Program if such Spouse of Record/Domestic Partner of Record was an eligible Dependent at the time of the death of such Retiree or 60 Point Retiree Medical Severance Plan Participant or LTD Participant.

**Survivor:**

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

**Termination of Domestic Partnership:**

In order to meet the definition of "Termination of Domestic Partnership", the Retiree (or 60 Point Retiree Medical Severance Plan Participant or LTD Participant) 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.

**UCEPP:**

UCEPP” means the UCEPP component of the Union Carbide Employees’ Pension Plan.

**Union Carbide:**

Union Carbide Corporation and its subsidiaries and affiliates, which it has authorized to participate in the Program. “Union Carbide” and “Participating Employers” have the same meaning and are used interchangeably.

## Section 26. Claims Procedures for Claims for an Eligibility Determination

**Deadline to file a Claim:** All Claims must be filed in the same calendar year that the service was rendered, or during the following calendar year. Failure to file a Claim within the deadline will result in denial of the Claim.

A *Claim for an Eligibility Determination* is a written request for a determination as to whether a claimant is eligible to participate in the Program. The initial determination for a *Claim for an Eligibility Determination* is made by the Initial Claims Reviewer. The Initial Claims Reviewer is the U.S. Health and Welfare Leader for The Dow Chemical Company. If you appeal, the appellate decision is made by the Global Director of Benefits for The Dow Chemical Company. The Global Director of Benefits is the Appeal Administrator. See Section 26.1 for how to file a *Claim for an Eligibility Determination*, or how to appeal a denial of eligibility to participate in the Plan.

A *Claim for a Plan Benefit* is a written request that the Plan pay for benefits covered under the Plan. The Claims Administrator for *Claims for Plan Benefits* is applicable Self-Funded HMO administrator listed in ERISA Information section of this SPD. See the applicable Appendix A of this SPD for the applicable *Description of Benefits*, for how to file a Claim for a Plan Benefit, or how to file an appeal of a denial of a Plan Benefit.

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

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 claims 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 the Program under s.502 of the Employee Retirement Income Security Act (ERISA) in federal court. If you file a lawsuit, you must do so within 120 days from the date of the Appeals Administrator's final written decision. Failure to file a lawsuit within the 120-day period will result in your waiver of your right to file a lawsuit.

### 26.1 How to File a Claim for an Eligibility Determination

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.

#### Initial Determination:

If you submit a Claim for an eligibility determination, the Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days of the date you submitted your Claim; except that

under special circumstances, the Initial Claims Reviewer can have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer needs such an extension, it will notify you prior to the expiration of the initial 90-day period, state the reason why such an extension is needed and state when it will make its determination.

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

Claims for eligibility determinations must be sent to:

U.S. Health and Welfare Leader  
The Dow Chemical Company  
Employee Development Center  
Midland, Michigan 48674  
Attention: Initial Claims Reviewer for Union Carbide Corporation Self-Funded HMO Plan

## **Appealing the Initial Determination:**

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

Global Director of Benefits  
U.S. Benefits Center  
Employee Development Center  
Midland, Michigan 48674  
Attention: Appeals Administrator of Union Carbide Corporation Self-Funded HMO Plan (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 Global Director of Benefits under applicable federal regulations. Your request must be in writing. Such information will be provided at no cost to you.

After the Global Director of Benefits receives your written request to appeal the initial determination, the Global Director of 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 Global Director of Benefits is not the same person as the person who made the initial decision to deny the Claim. In addition, the Global Director of Benefits is not a subordinate who reports to the person who made the initial decision to deny the Claim. The Global Director of 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 Global Director of Benefits can have up to an additional 60 days to provide written notification of the final decision. If the Global Director of 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 Global Director of 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 Global Director of 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 Global Director of Benefits to make its decision is “put on hold” until it receives the requested information.) The tolling period ends when the Global Director of Benefits receives your response, regardless of the adequacy of your response.

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

## Section 27. For More Information

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

# **APPENDIX A**

## **Description of Plan Benefits**

# APPENDIX B

## Notice of Privacy Practices

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

The Union Carbide Corporation Retiree Medical Care Program (the “Program”), including its Self-Funded HMO Plans, is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Program.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information. In addition, the Program may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health Program, which summarizes the claims history, claims expense or type of claims experienced by individuals for whom a Program sponsor has provided health benefits under a group health Program; and from which identifying information has been deleted in accordance with HIPAA.

### **B 1. Notice of PHI Uses and Disclosures**

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**Required PHI Uses and Disclosures:**

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

Uses and disclosures to carry out treatment, payment and health care operations:

The Program and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Program also will disclose PHI to the applicable Plan Sponsor<sup>9</sup> for purposes related to treatment, payment and health care operations. As of April 14, 2003, the Plan Sponsors have amended the plan document to protect your PHI as required by federal law.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Program may disclose to a treating orthopedic specialist the name of your treating family physician so that the orthopedic specialist may ask for your X-rays from the treating family physician.

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Program may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Program.

*Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Program may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

**Uses and disclosures that require your written authorization:**

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

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

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

**Uses and disclosures for which consent, authorization or opportunity to object is not required:**

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

1. When required by law.
2. When permitted for purposes of public health activities, included when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be the victim of abuse, neglect or domestic violence. In such case, the Program will promptly inform you that such a

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<sup>9</sup> The Plan Sponsor is The Dow Chemical Company.

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

## **B 2. Rights of Individuals**

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### **Right to Request Restrictions on PHI Uses and Disclosures:**

You may request the Program to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Program is not required to agree to your request. The Program will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following person: Privacy Official; Union Carbide Corporation Retiree Medical Care Program; Employee Development Center, Midland, MI 48674.

**Right to Inspect and Copy PHI:**

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Program maintains the PHI.

“*Protected Health Information*” (PHI) includes all individually identifiable health information transmitted or maintained by the Program, regardless of form.

“*Designated Record Set*” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Program is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following person: Privacy Official; Union Carbide Corporation Retiree Medical Care Program; Employee Development Center, Midland, MI 48674. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

**Right to Amend PHI:**

You have the right to request the Program to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Program has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Program is unable to comply with the deadline. If the request is denied in whole or in part, the Program must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following person: Privacy Official; Union Carbide Corporation Retiree Medical Care Program; Employee Development Center, Midland, MI 48674. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make your request for amendment in writing, provide the name of the applicable benefit plan you are requesting the amendment under, and provide the reason(s) to support the amendment you are requesting.

**The Right to Receive an Accounting of PHI Disclosures:**

At your request, the Program will also provide you with an accounting of disclosures by the Program of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to an individual’s authorization; or (4) prior to the compliance date. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Program may charge a reasonable, cost-based fee for each subsequent accounting.

**The Right to Receive a Paper Copy of This Notice Upon Request:**

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

### **A Note About Personal Representatives:**

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

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

The Program retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

## **B3. The Program's Duties**

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The Program is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This notice is effective beginning April 14, 2003 and the Program is required to comply with the terms of this notice on and after that date. However, the Program reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Program prior to and after that date. If a privacy practice is changed, a revised version of this notice will be provided participants and beneficiaries for whom the Program still maintains PHI. The notices may be provided in the Choices enrollment brochures and updated versions of the summary plan descriptions, or other appropriate means of communication. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Program or other privacy practices stated in this notice.

### **Minimum Necessary Standard:**

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

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

## **B 4. Your Right to File a Complaint**

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

## **B 5. Whom to Contact at the Program for More Information**

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If you have any questions regarding this notice or the subjects addressed in it, you may contact the following person: Privacy Official; Union Carbide Corporation Retiree Medical Care Program; Employee Development Center, Midland, MI 48674

**Conclusion:** PHI use and disclosure by the Program is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act.) You may find these rules at 45 *Code of Federal Regulations* parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

# APPENDIX C

## Important Notice of Creditable Coverage For Medicare-Eligibles Applicable to Plan Year 2011

**The following plans provide Creditable Coverage for prescription drugs:**

- Blue Care Network
- Blue Cross/Blue Shield of Michigan (Illinois)
- CIGNA
- HealthPartners Minnesota
- Humana

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Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Union Carbide Corporation Retiree Medical Care Program (including the Self Funded HMO Plans) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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### 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 15<sup>th</sup> through December 31<sup>st</sup>.

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

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

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following 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](http://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](http://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, 2010
Name of Entity/Sender:	Union Carbide Corporation c/o 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