

Summary Plan Description “Wrapper” for:

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

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

**Amended and Restated December 23, 2010
Effective January 1, 2011 and thereafter until superseded.**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.**

Table of Contents

Section	Page
Section 1. ERISA Information	1
Section 2. Summary Plan Description “Wrapper”	3
Section 3. About HMOs.....	5
3.1 How HMOs Operate	5
3.2 Dow, Union Carbide and HMOs and Insured Plans	6
3.3 Information that Your HMO or Insured Plans Should Provide You ...	6
3.4 Secova, the HMO Network Manager	7
3.5 Medicare Advantage Plans	7
Section 4. Eligibility.....	8
4.1 General Eligibility.....	8
4.2 Retiree Eligibility	8
4.3 Long Term Disability Participants	11
4.4 60 Point Retiree Medical Severance Plan Participants	12
4.5 Special Eligibility Provisions for Mergers and Acquisitions and Other Special Situations.....	12
4.6 Dependent Eligibility.....	12
▪ Qualified Medical Child Support Orders	
▪ Dependent Child Exclusions	
▪ Spouse of Record/Domestic Partner of Record Exclusions	
4.7 The Working or Retired Spouse of Record/Domestic Partner of Record Rule.....	15
▪ Waiving Coverage-Working or Retired Spouse of Record/Domestic Partner of Record	
4.8 Exception to the Working or Retired Spouse of Record/ Domestic Partner of Record Rule.....	16
4.9 Remarriage or New Domestic Partnership.....	17
4.10 Before You Become Medicare-Eligible, You Should Know.....	17
▪ Retiree Less Than 65 Years of Age	
▪ Retiree Age 65 or Older	
4.11 Pre and Post-Medicare Family	18
4.12 Eligibility Determinations of Claims Administrator are Final and Binding	19

Section	Page
Section 5. Enrollment	20
5.1 Levels of Participation	20
5.2 Enrolling at Retirement.....	20
5.3 Annual Enrollment	20
5.4 Dual Dow/UCC Eligibility	22
5.5 What if I Am Enrolled in an HMO that Does Not Accept Retirees Who are Medicare-Eligible, and I Become Medicare-Eligible?	22
5.6 What if I Am Enrolled in an HMO and I Want to Switch to UCC’s Self-Insured MAP Plus, Catastrophic Medical Plan or Prescription Only Plan.....	22
5.7 Special Enrollment Provisions Under Health Insurance Portability And Accountability Act	23
5.8 If You Move During the Plan Year	23
Section 6. Mid-Year Election Changes.....	24
6.1 Change in Status	24
6.2 Consistency Rule	24
▪ Exceptions	
6.3 Documentation of Eligibility Required to Make Election Change.....	25
6.4 Dropping a Dependent.....	25
6.5 Deadline to Enroll for Mid-Year Changes	25
Section 7. Premiums and Premium Caps	26
▪ Premiums	
▪ UCC Retiree Medical Budget (“Maximum UCC Subsidy” or “Premium Cap”)	
▪ Premium Cap for <u>Pre-Medicare Eligible Full Service Retirees</u>	
▪ For Retirees Who Are <u>Pre-Medicare Eligible Who Do Not Have</u> Full Service	
▪ Premium Cap for <u>Medicare-Eligible Who Have Full Service</u>	
▪ For Participants Who Are <u>Medicare-Eligible Who Do Not Have</u> Full Service	
▪ 60 Point Retiree Medical Severance Plan Participants	
▪ Special Interim Rule for Retirees Whose Employment was Involuntarily Terminated Between 8/1/03 and 1/1/04	
7.1 If Medicare is NOT Primary	30
7.2 Premium Payments/Excess Premium Payments	30

Section	Page
Section 8. Survivor Benefits	31
8.1 Surviving Spouses/Domestic Partners of Deceased Active Employees	31
8.2 Surviving Spouses of Record/Surviving Domestic Partners of Record of Deceased Retirees and Deceased 60 Point Retiree Medical Severance Plan Participants	31
8.3 Surviving Spouses of Record/Surviving Domestic Partners of Record of Deceased LTD Plan Participants	32
8.4 Surviving Child(ren)	33
Section 9. HIPAA and Other Laws.....	34
9.1 Health Insurance Portability and Accountability Act of 199 (HIPAA) and Other Legislation	34
▪ Women’s Health and Cancer Rights Act of 1998	
▪ Maternity Stays	
▪ Certificates of Coverage	
▪ Information Exchanged by the Program’s Business Associates	
Section 10. Filing a Claim	36
10.1 Filing Claims for Benefits and Appealing Claims Denials.....	36
Section 11. Fraud Against the Program	37
11.1 Fraud Against the Program.....	37
Section 12. Ending Coverage	38
12.1 When Coverage Ends.....	38
12.2 COBRA Continuation Coverage.....	38
Section 13. Grievance Procedure	45
Section 14. Your Legal Rights Under ERISA.....	46
Section 15. Plan Administrator’s Discretion	48
Section 16. Welfare Benefits.....	49
Section 17. The Company’s Right to Terminate or Amend the Program	50
Section 18. Disposition of Plan Assets If the Program is Terminated	51
Section 19. Class Action Lawsuits.....	52
Section 20. Funding	53
Section 21. Payment of Unauthorized Benefits	54

Section 22. For More Information	55
APPENDIX A Definitions of Terms	56
APPENDIX B Claims Procedures	70
APPENDIX C Important Notice of Creditable Coverage	74

Section 1. ERISA Information

SPD Wrapper for Union Carbide Corporation Retiree Insured Health Program	
Plan Sponsor:	Union Carbide Corporation, a subsidiary of The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Plan Administrator:	U.S. Health and Welfare Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (989) 638-8757
Employer Identification Number:	13-1421730
Plan Number:	555
Administrators:	With respect to claims and questions concerning benefits coverage: The applicable HMO or insured health plan With respect to eligibility to participate in the Program: U.S. Health and Welfare Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (989) 638-8757
Retiree Service Center	Union Carbide Corporation c/o The Dow Chemical Company U.S. Benefits Center Employee Development Center Midland, MI 48674 (800) 344-0661 or (989) 636-0977
To Serve Legal Process, File With:	The applicable HMO or insured health plan at the address provided by the HMO or insured health plan.
HMO Network Manager	Secova is the HMO Network Manager for HMOs offered to Retirees and their Dependents. Secova (formerly UltraLink) 535 Anton Boulevard, Suite 900 Costa Mesa, California 92626 (800) 7DOWDOW or (800) 858-4347

January 1, 2011 UCC HMOs Summary Plan Description

COBRA:	<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 34th Street South St. Petersburg, Florida 33711-3828 (800) 877-7994</p>
Plan Year:	<p>Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.</p>
Funding:	<p>Union Carbide and Participating Employers share the premium costs with Retirees. The Company's share of the premium costs is limited to the retiree medical budget established in January 2000 and July 2003.</p> <p>Benefits are underwritten by the applicable HMO or insured plan.</p> <p>The applicable HMO or insured plan is liable to pay the benefits, not any Participating Employer or The Dow Chemical Company.</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>

Section 2. Summary Plan Description “Wrapper”

This is the Summary Plan Description (SPD) “wrapper” (SPD Wrapper) for Health Maintenance Organizations (HMO’s) and insured health plans that are offered through the Union Carbide Corporation Retiree Insured Health Program (Program), formerly known as the Union Carbide Corporation Insured/HMO Medical Program for Pre-Medicare and Medicare-Eligible Retirees) as applicable to eligible Retirees. This SPD Wrapper addresses:

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

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

- Eligibility requirements of the applicable HMO or insured plan
- Benefits covered under the applicable HMO or insured plan and the coverage levels
- Terms and Conditions for benefits coverage under the applicable HMO or insured plan
- Co-pays, deductibles, out-of-pocket maximums, coverage limitations
- Filing and appealing Claims for Benefits
- Pre-certification or pre-authorization requirements
- In-network and out-of-network provisions, if any
- Primary care physician requirements, if any
- Any other provisions of the applicable HMO or insured plan

This SPD Wrapper, together with the material provided by the applicable HMO or insured plan, is intended to constitute the “Summary Plan Description” for the applicable HMO or insured plan. However, it does not contain all of the information. Further information can be found in the Plan Document for the Union Carbide Corporation Retiree Insured Health Program (formerly known as the Union Carbide Corporation Insured/HMO Medical Program for Pre-Medicare and Medicare Eligible Retirees), a copy of which is available from the Plan Administrator. If there is a discrepancy between this SPD Wrapper and the Plan Document, the Plan Document will govern. You may request a copy of the Plan Document from the Plan Administrator. See the *ERISA Information* section of this SPD Wrapper for the Plan Administrator’s name and address.

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

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

The provisions of this SPD Wrapper only apply to HMOs and insured plans offered through the Union Carbide Retiree Insured Health Program (formerly known as the Union Carbide Insured/HMO Medical Program for Pre-Medicare and Medicare Eligible Retirees). Call the Retiree Service Center at (800) 344-0661 for information about the Union Carbide self-insured programs applicable to eligible Retirees that are offered through the Union Carbide Corporation Retiree Medical Care Program.

Words that are capitalized are either defined in the Plan Document for the Program or in *APPENDIX A* under *Definitions of Terms*. When used in this Summary Plan Description and communications to Retirees, “Participating Employer” or “Union Carbide” refers to the Union Carbide Corporation, and its subsidiaries and affiliates that have been authorized to participate in these benefit Plans.

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

Section 3. About HMOs

Union Carbide offers HMOs to Pre-Medicare eligible Retirees and their eligible Spouses of Record/Domestic Partners of Record and eligible Dependent children at certain locations.

Union Carbide also offers Medicare Advantage HMO's in certain locations to Medicare Eligible Retirees and their eligible Spouses of Record/Domestic Partners of Record as an alternative to traditional Medicare Parts A and B and the self-insured plan offered under the Union Carbide Corporation Retiree Medical Care Program.

Contact Secova to find out if an HMO is available to you and for more information. Contact information for Secova can be found in Section 1 entitled *ERISA Information*.

3.1 How HMOs Operate

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

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

Medicare HMOs provide coverage for all services covered by traditional Medicare, plus HMOs usually provide coverage for additional services. If you enroll in a Medicare HMO, you no longer have traditional Medicare Parts A and B. All of your medical services must be obtained through the HMO network of providers.

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

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

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

HMOs should not refuse to provide services or coverage because of a labor dispute involving employees of the HMO. Generally, you will not be billed directly by the HMO for any medical services—except for charges such as Copayments for services only partially covered by the HMO. Any charge not paid by the HMO becomes your responsibility—not UCC's. If an HMO fails to pay a charge directly to a health care provider or fails to provide coverage for an expense you feel should be covered, the disagreement should be settled between you and the HMO.

3.2 Dow, Union Carbide and HMOs and Insured Plans

When you enroll in an HMO or an insured plan, you are not enrolled in a benefit plan designed or administered by Union Carbide or Dow (except for TDCC's involvement as the Plan Administrator in determining whether you meet the Program's eligibility rules described in this SPD Wrapper). Instead, you are enrolled in an independent medical plan that is operated by an HMO entity or insurance company separate from Union Carbide or Dow. By joining an HMO or insured plan you agree to obtain your health care coverage through the HMO or insured plan. Union Carbide and Dow's primary contact with the HMO or insurance carrier is the payment of premiums, your portion (through pension check deduction or invoicing) and the Company's.

Any disagreement between you and the HMO or insurance carrier becomes a matter to which you and the HMO or insurance carrier should respond. For example, if you disagree with the HMO or insurance carrier over a settlement of a Claim, or have any questions concerning a Physician referral, you should follow the review and appeals procedures of that HMO or insurance carrier.

Any charge not paid by the HMO or insured plan is your responsibility, not Union Carbide's or Dow's. If an HMO or insured plan fails to pay a charge directly to a health care provider or fails to provide coverage for an expense you feel should be covered, the disagreement should be settled between you and the HMO or insured plan.

3.3 Information that Your HMO or Insured Plan Should Provide You

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

- the nature of services provided the HMO's or insured plan's members;
- conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility required by Union Carbide described in this SPD Wrapper);
- the circumstances under which services can be denied;

- the procedures to be followed in obtaining such services, and the procedures available for the review of the Claims for Benefits that are denied in whole or in part.

Secova can assist you in obtaining these HMO materials if you need help getting them from the HMO. The Plan Administrator can assist you in obtaining these materials from the insured plan. Contact information for Secova and the Plan Administrator can be found in Section 1 entitled *ERISA Information*.

3.4 Secova, the HMO Network Manager

The Company has hired Secova (formerly UltraLink) to manage the HMOs that participate in the Union Carbide HMO/Insured Health Program. If you would like more information regarding the availability of HMOs in your area, or do not know how to contact your HMO, contact Secova, the Insured Health Program's HMO Network Manager, at (800) 7DOWDOW. In addition, your Choices open enrollment materials also will provide you with further details.

3.5 Medicare Advantage Plans (Medicare HMO's)

The HMO's offered under the Union Carbide Corporation Insured Health Program that are available to those who are eligible for Medicare are HMO's that have been approved by the government as "Medicare Advantage Plans with Prescription Drug Coverage" ("Medicare Advantage Plans").

Section 4. Eligibility

4.1 General Eligibility

Besides meeting the eligibility criteria described in this SPD Wrapper, in order to participate in a particular HMO or insured plan, you must be located where the HMO or insured plan is available. In addition, some HMO's do not provide coverage to Medicare Eligible individuals. If enrolling in a Medicare HMO, you must be enrolled in Medicare Parts A and B.

4.2 Retiree Eligibility

Definition of 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 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 terminated¹ 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 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”.

A “Retiree’s” eligibility for coverage depends on a number of factors²:

1. The Retiree must have been hired prior to January 1, 2008³; and

² 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.

³ 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

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.)

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:

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.

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

4.3 Long Term Disability Participants

Except as otherwise provided⁴, 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

⁴ If you are receiving LTD payments because of your employment with The Dow Chemical Company or the 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.

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.

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.

4.4 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.

4.5 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.

4.6 Dependent Eligibility

Eligible Retirees 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 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
- the natural or adopted child of your Spouse of Record or your Domestic Partner of Record, or
- a child for whom you or your Spouse or Domestic Partner of Record have the permanent legal guardianship or permanent legal custody as those terms are defined under the laws of the state of Michigan. Child(ren), including grandchild(ren), not specifically identified in the first two bullets above, are not eligible for coverage as Dependents unless both their biological parents are deceased, or have permanently “legally relinquished all of their parental rights” in a court of law. “Legally relinquished all of their parental rights,” means that the biological parents permanently do not have the:
 -
 - authority to consent to the child’s Marriage or adoption, 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 26th birthday, may continue coverage.

If you enroll your Domestic Partner's child(ren), you must have the Plan Administrator's "Statement of Domestic Partnership 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 the Program if he:

- 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 26th birthday. Children age 26 or older are not eligible. However, coverage may continue beyond age 26 if, prior to age 26, he or she is incapable of self-sustaining employment because of a physical or mental disability and is covered under the Plan on the day prior to reaching age 26. The child must be principally dependent upon you for support. Proof of the child's initial and continuing dependency and disability must be provided to the Plan prior to age 26 in order for coverage to continue. You must make any contribution required by the Plan to continue coverage for your child. Once the coverage is terminated, it cannot be reinstated. Contact the HR Service Center at (877) 623-8079 or 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; or

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's⁵ 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.

4.7 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 Records' 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

⁵ As used in the *Spouse Exclusions* paragraphs of this SPD, "employer" means someone who employs another. It also includes the partner or owner of a business. As used in these sections, "employees" (without a capital "e") includes partners and owners, as well as those who are providing Services in an employer-employee relationship. These definitions also apply to the sections of this SPD entitled *The Working or Retired Spouse of Record/Domestic Partner of Record Rule*; *Waiving Coverage-Working or Retired Spouse of Record/Domestic Partner of Record*; and *Mid-Year Election Changes*.

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 HMO or insured plan offered by UCC in order to save premium dollars.

4.8 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 Insured Health Program. Note that if you Retired prior to December 31, 2002, and you remarried prior to December 31, 2002, or filed a Domestic Partner statement satisfactory to the Plan Administrator prior to December 31, 2002, you may cover that Spouse of Record/Domestic Partner of Record.

4.9 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 Dow sponsored retiree medical program.

4.10 Before You or Your Dependent Becomes Medicare-Eligible, You Should Know...

Retiree Less than 65 Years of Age

Generally once you or your Spouse of Record/Domestic Partner of Record are eligible for Medicare, you are no longer eligible to participate in the Program. However, if you are a Retiree who was hired prior to February 6, 2001, you are eligible to participate in the Program. If you are eligible for UCC coverage when you are eligible for Medicare, during the three month period before you reach age 65, you need to enroll in Medicare Parts A and B in order to continue receiving benefits through the Program. The same guidelines apply for your Spouse of Record/Domestic Partner of Rec.

Note: If the eligible Retiree or Spouse of Record/Domestic Partner of Record becomes eligible for Medicare due to disability, or for any other reason, before the eligible Retiree reaches age 65, such eligible Retiree, Spouse or Domestic Partner must enroll in Medicare Parts A and B within the deadlines set by Medicare or you must enroll in a Dow approved Medicare Advantage HMO. The above-described Medicare enrollment is necessary in order to be eligible for maximum benefits under the Program. Contact the Retiree Service Center for more information.

If you were hired prior to February 6, 2001, and are less than age 65 and have Medicare coverage due to End-Stage Renal Disease (kidney failure), you may continue coverage under the Program until age 65. Your Program coverage will be primary to Medicare for the first 30 months. After the first 30 months, Medicare will become the primary payer and the Program will be the secondary payer.

If you are a Retiree who was hired on or after February 6, 2001, once you are eligible for Medicare you are not eligible for coverage under the Program, or any other retiree medical plan sponsored by Union Carbide. If you lose eligibility for coverage under the Program because you are eligible for Medicare, and you have a Spouse of Record/Domestic Partner of Record who is not eligible for Medicare, he or she may continue eligibility under the Program, but must pay 102% of the full unsubsidized cost to insured based on his or her age. Once he or she is eligible for Medicare, eligibility for coverage under the Program ends. If your Spouse of Record/Domestic Partner of Record is eligible for Medicare before you are, then he or she loses eligibility for coverage under the Program at the time he or she is eligible for Medicare. Dependent children may continue coverage as long as the Retiree or Spouse of Record/Domestic Partner of Record is eligible for coverage under the Program. Such Dependent children are subject to the corresponding rate. 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.

Retiree Age 65 or Older

The following guidelines apply to you and your Spouse of Record/Domestic Partner of Record:

- If you Retire when you each age 65, you must enroll in both Parts A and B of Medicare to be eligible for coverage. Enrollment should take place during the three month period prior to reaching age 65.
- If you Retire after reaching age 65, you should enroll in Part A during the three month period prior to your 65th birthday, and in Part B during the three month period prior to Retirement. You should also consider enrolling in Medicare Part D.
- If you are eligible for UCC coverage when you are eligible for Medicare, you may enroll in a Medicare Advantage HMO offered under the Program, instead of enrolling in Medicare Part A and B.

If you did not enroll according to these guidelines, you may not do so until the first quarter of the following year (January, February or March), with coverage beginning on July 1. Medicare will charge you a penalty when you do enroll. For details about Medicare, obtain a copy of your Medicare Handbook from your local Social Security Officer or the Health Care Finance Administration, or contact one of these offices with your questions.

Requirement to Enroll in Medicare if You or Your Dependent is Eligible for Medicare

If you and/or your dependent(s) do not enroll in Medicare Parts A and/or B as soon as your and/or your dependent(s) are eligible, the Union Carbide Program will NOT pay for claims which would have otherwise been paid by Medicare had you and/or your eligible dependent(s) enrolled in Medicare Parts A and B.

4.11 Pre and Post-Medicare Family

Some HMOs do not provide coverage for persons who are eligible for Medicare. In addition, some HMO's do not provide coverage to families with members that are both pre-Medicare and post-Medicare-eligible. If you are enrolled in one of these HMOs, you will not be able to continue HMO coverage. If you are eligible for UCC coverage when you are eligible for Medicare, you may change your coverage to a self-insured plan under the Union Carbide Corporation Retiree Medical Care Program. Check with your HMO to determine whether it has such restrictions, and if it does, check the summary plan description for the Union Carbide Corporation Retiree Medical Care Program to see which of its plans are available to you. Eligibility requirements vary depending on Medicare-eligibility.

4.12 Eligibility Determinations of Claims Administrator are Final and Binding

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

Section 5. Enrollment

5.1 Levels of Participation

Levels of Participation

The levels of participation available are:

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

The Retiree must be enrolled in order to enroll a Dependent Spouse of Record/Domestic Partner of Record or Dependent child. See also section of this SPD entitled *Pre and Post-Medicare Family*.

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

5.2 Enrolling at Retirement

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, such as 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 required by the Plan Administrator will result in no coverage for your Dependents.**

5.3 Annual Enrollment

Enrollment is typically held during the last quarter of the year. You can enroll for coverage, switch from an HMO (or insured plan) to a self-insured plan sponsored by UCC, 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, please be sure that he or she meets the definition of a Spouse of Record or Domestic Partner of Record in Appendix

Note that if you enroll or dis-enroll in a Medicare Advantage Plan (i.e., a Medicare HMO), the enrollment or disenrollment must be approved by the Centers for Medicare

and Medicaid Services (“CMS”). CMS is the government agency that administers Medicare. Your election to enroll or dis-enroll in a Medicare HMO offered by the Union Carbide Program is not effective until the Medicare HMO has received approval from CMS. Until such approval by CMS is received by the Medicare HMO, the plan administrator of the Union Carbide Program may enroll you in an alternative option until CMS approval is received.

If, at annual enrollment, you do not have employer/former employer or private-individual coverage, you may not enroll in the Program. 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 Union Carbide Corporation Retiree Medical Care Program. In order to be eligible for the UCC Retiree Insured Health Program, you must have been covered under the UCC Catastrophic Medical Plan for a period of two years immediately prior to enrolling in the UCC Retiree Insured Health Program. This rule is waived if you are enrolled in Medicare Parts A and B. Beginning January 1, 2010, the Catastrophic Medical Plan is not available to the Medicare-eligible.

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 family level coverage or Individual 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 birth certificates, passports, Marriage certificate, proof of Domestic Partnership 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.**

If your Spouse is enrolled in a plan, you may not dis-enroll your Spouse of Record in anticipation of a divorce. You are required to continue coverage for your Spouse of Record and pay the applicable premium. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), when your legal separation or divorce is final, your Spouse of Record has a right to continue coverage under the Plan at

102% of the full cost of coverage for a certain period of time. See *Your Rights to Continuation Coverage Under COBRA* in this SPD for more information about COBRA coverage.

5.4 Dual Dow/UCC Eligibility

If you and your 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)

5.5 What if I Am Enrolled in an HMO that Does Not Accept Retirees Who are Medicare-Eligible, and I Become Medicare-Eligible

If you are not yet eligible for Medicare and enrolled in an HMO that does not accept Retirees who are eligible for Medicare, when you become eligible for Medicare, you may switch to a different HMO that does accept Medicare, or you may switch to a UCC self-insured plan under The Union Carbide Retiree Medical Care Program. This assumes you are eligible for UCC coverage when you are eligible for Medicare. See Section 4.2 regarding eligibility.

5.6 What if I Am Enrolled in an HMO and I Want to Switch to UCC's Self-Insured MAP Plus, or Catastrophic Medical Plan?

If you are enrolled in the Program, and you are age 65 or older and enrolled in a Medicare HMO, you may switch to a retiree medical plan under UCC's self-insured retiree medical program at any time you dis-enroll in a Medicare HMO. You must send a written request to the HMO to cancel your HMO coverage and contact the Retiree Service Center to enroll in a UCC self-insured retiree medical plan. Your written cancellation request must be received by the HMO by the end of the month prior to the month in which you want your coverage to switch. You will not be required to prove good health to switch from a Medicare HMO to UCC's self-insured retiree medical program. No proof of health is required to switch plans. This assumes you are eligible for UCC coverage when you are eligible for Medicare. See Section 4.2 regarding eligibility.

If you are enrolled in the Program, and you are NOT age 65 or older, you may only switch to a retiree medical plan under UCC's self-insured retiree medical program during

annual enrollment or a change of address that causes you or your Dependents to lose eligibility for the HMO, in which you are currently enrolled.

5.7 Special Enrollment Provisions

If you decline enrollment in coverage under the Program for yourself or your Dependents (including your Spouse/Domestic Partner because you have other health insurance coverage, you may in the future enroll yourself or your eligible Dependents outside of Dow's usual open enrollment period if you or your Dependent lose eligibility for the other coverage or the other employer ceases to make employer contributions for the other coverage. In order to have UCC sponsored HMO/insured plan coverage, you or your eligible Dependent must enroll in the UCC sponsored HMO/insured plan coverage within 90 days after the other coverage ends. (60 days for the Aetna Medicare Open Plan). However, if you or your Dependent declined UCC sponsored HMO/insured plan 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. (60 days for the Aetna Medicare Open Plan). 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. (60 days for the Aetna Medicare Open Plan).

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.

5.8 If You Move During the Plan Year

If you move during the plan year and your HMO is not offered at your new location, you may switch your coverage to an HMO that is available at the new location or switch to one of UCC's self-insured retiree medical plans.

Section 6. Mid-Year Election Changes

You may **drop** a Dependent from coverage or waive coverage for yourself at any time. 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 as Spouses, to the extent that such administration does not jeopardize the tax qualified status of the program.

6.1 Change in Status

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

- Divorce or Termination of Domestic Partnership, death of Spouse of 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 or 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 for “Dependent child”.
- Spouse of Record/Domestic Partner of Record gains eligibility for coverage under the Spouse/Domestic Partner’s employer’s health plan.

6.2 Consistency Rule

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

- The change in status must result in you, your Spouse of Record/Domestic Partner of Record, or your Dependent child gaining or losing eligibility for coverage under either the UCC Medical Plan or the parallel plan of your Spouse of Record/Domestic Partner of Record’s employer.
- The election change to the UCC Medical Plan 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 UCC Medical Plan election. 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 UCC Medical Plan election.

6.3 Documentation of Eligibility Required to Make Election Change

Documentation is required to make an election change (such as birth certificates, passports, evidence of loss of Spouse of Record/Domestic Partner of Record'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.

6.4 Dropping a Dependent

You may drop a Dependent at any time (except in anticipation of a divorce, per the COBRA rules). You must notify the Retiree Service Center. Failure to notify the Retiree Service Center will result in your continued obligation to pay the premiums. Further, if you or your Dependent is no longer eligible for coverage, you must notify the Retiree Service Center, otherwise, you may continue to be obligated to pay the premiums until the date you notify the Retiree Service Center, AND coverage will be dropped retroactively effective the date of ineligibility.

6.5 Deadline to Enroll for Mid-Year Changes

If you meet the requirements allowing you to make a mid-year election change (any change made at any time outside of open enrollment period, typically in the fall), you must submit proof of eligibility within 90 days of the change in status event. (60 days for the Aetna Medicare Open Plan).

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 7. Premium and Premium Caps

Retirees who are eligible for UCC coverage and UCC share the cost for plan coverage and benefits according to the following guidelines:

Premiums:

The premium is the cost associated with Plan coverage. UCC pays part of this expense and you pay part of this expense. The portion that UCC pays toward the premium is completely separate from benefits payable under the Plan.

UCC Retiree Medical Budget (“Maximum UCC Subsidy” or “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 Service⁶ 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 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.**

⁶ “Service” is defined in *Appendix A - Definitions* section of this SPD.

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.**

Premium Cap for Medicare-Eligible Retirees Who Have Full Service:

The maximum UCC subsidy (premium cap) was set at two times Union Carbide's share of the monthly MSP Basic Plan A rate in January 2000. This means that the maximum amount the Company will contribute for each Full Service Medicare-eligible Retiree in a Union Carbide-sponsored health plan will be \$132.00 per month. Once the Company contribution has reached this limit, you are responsible for the full amount of all premium cost increases. **Once the maximum UCC subsidy is exceeded, it is very likely that you will experience significant increases in your retiree medical premiums.**

Prior to reaching the premium cap, if you are a Full Service Retiree, UCC contributes 50% of the total HMO premium or 50% of the MSP Basic Plan A premium, whichever is less, up to the maximum allowed under the premium cap. You are responsible for the balance.

For those who Retire on or after January 1, 2004, a "Full Service" Retiree is a Retiree who has 30 years of Service⁷ 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 prior 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.

For Participants Who Are Medicare-Eligible Who Do Not Have Full Service:

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

⁷ "Service" is defined in *Appendix A - Definitions* section of this SPD.

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 Service⁸</u> when employment with Union Carbide ends	<u>Your Contribution Towards the</u> Full Service Subsidy	<u>UCC's Contribution Towards the</u> Full Service Subsidy
10	60%	40%
11	57%	43%
12	54%	46%
13	51%	49%
14	48%	52%
15	45%	55%
16	42%	58%
17	39%	61%
18	36%	64%
19	33%	67%
20	30%	70%
21	27%	73%
22	24%	76%
23	21%	79%
24	18%	82%
25	15%	85%
26	13%	87%
27	11%	89%
28	9%	91%
29	7%	93%
30 or more*	0%	100%

* Special provisions may apply to certain Retirees who have Service with a company 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.

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

⁸ "Service" is defined in *Appendix A - Definitions* section of this SPD.

Attribution Schedule⁹ – 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 Schedule¹⁰ – 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
% 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 Interim Rule for Retirees Whose 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.

⁹ 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.

¹⁰ 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.

7.1 If Medicare is NOT Primary

Usually Medicare is primary if you are age 65 or older, or are disabled. However, sometimes Medicare is not primary, such as if you reside outside the U.S. When the UCC Plan provides the primary coverage instead of Medicare, you will be required to pay the premiums applicable to pre-Medicare-eligible Retirees.

7.2 Premium Payments/Excess Premium Payments

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

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 HMO or insured plan may cancel coverage retroactively, and may seek repayment of any benefit claims paid for an ineligible Dependent. In addition, the Plan Administrator may require that you continue to pay premiums at the same enrollment level until you change your coverage during the next open enrollment, even though coverage for your Dependent(s) was dropped retroactively effective to the date of ineligibility.

Section 8. Survivor Benefits

8.1 Surviving Spouses/Domestic Partners of Deceased Active Employees

In general, surviving Spouses/Domestic Partners whose Spouse died while actively employed at UCC are offered coverage through the UCC Retiree Medical Care Program. (This does not apply to survivors of The Dow Chemical Company. See summary plan description for The Dow Chemical Company 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 50th 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.

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

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.

8.3 Surviving Spouses of Record/Surviving Domestic Partners of Record of Deceased LTD Plan Participants

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.

8.4 Surviving Child(ren)

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.

Section 9. HIPAA and Other Laws

9.1 Health Insurance Portability and Accountability Act of 1996 (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 UCC coverage ends, your HMO or insured plan will mail you a certificate of coverage stating the dates you were covered under UCC's Plan and the type of coverage you had [i.e., Retiree Only, Family, Retiree plus Spouse of Record/Domestic Partner of Record, Retiree plus Child(ren)]. 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 UCC coverage towards the waiting period. If you elect to continue UCC coverage under COBRA, when your COBRA coverage ends, you will receive another certificate of coverage from your HMO or insured plan. 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 coverage ceases by contacting your HMO or insured plan.

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

Information Exchanged by the Program's Business Associates

The Company and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates (including, but not limited to, to the HMOs and insured plans) under contract with the Company and the Plan Administrator for purposes of administering the Program. Aggregate data and summary health information, as defined by HIPAA, may be used by the Plan Sponsor to evaluate Program design changes and premium sharing ratios. The Program's business associates have entered into contracts with the Company and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA.

Section 10. Filing a Claim

10.1 Filing Claims for Benefits and Appealing Claims Denials

If you want to file or appeal a denial of a Claim for Plan Benefits, follow the claims procedures of your specific HMO or insured plan. You can obtain a copy of your HMO's or insured plan's Claims Procedures from your HMO or insured plan. If you need help contacting your HMO, contact Secova. If you need help contacting your insured plan, contact the Plan Administrator. Contact information for Secova and the Plan Administrator can be found in Section 1 entitled *ERISA Information*.

If you want to file a Claim for an Eligibility Determination, or appeal of denial of eligibility to participate in the Program, see the claims procedures in *APPENDIX B* of this SPD Wrapper.

Section 11. Fraud Against the Program

11.1 Fraud Against the Program

Any Participant who intentionally misrepresents information to the Program or an HMO/insured plan or knowingly misinforms, deceives, or misleads the Program or an HMO/insured plan, or knowingly withholds relevant information, may have his/her coverage cancelled retroactively to the date deemed appropriate by the Plan Administrator. Further, such Participant may be required to reimburse the HMO/insured plan for Claims paid by the HMO/insured plan. The Program or the HMO/insured plan may choose to pursue civil and/or criminal action. The Plan Administrator may determine that such Participant (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 The Dow Chemical Company or any of its subsidiaries or affiliates because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that the Participant (who could be the 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, contact the Retiree Service Center at (800) 344-0661. You may qualify for a reduction in your monthly premium. Complete and return a new enrollment form or call the Retiree Service Center within 90 days of the loss of eligibility. If you qualify for a reduction in premium, the premium will be reduced effective the date you contact the Retiree Service Center.

The loss of coverage for your Dependent, however, will occur on the date your Dependent becomes ineligible, whether or not a reduction in your monthly premium occurs.

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 the Program when you would otherwise lose your group health coverage.

Although COBRA does not apply to Domestic Partners, the Program will provide Domestic Partners 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
1(800) 344-0661

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 34th 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 of Record, 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 the Spouse of Record of a Retiree, you will become a qualified beneficiary if you lose your coverage under the Program because of any of the following qualifying events:

- (1) Your Spouse dies;
- (2) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (3) You become divorced 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-Retiree dies;
- (2) The parent-Retiree becomes enrolled in Medicare (Part A, Part B, or both);
- (3) The parents become divorced; or

- (4) The child stops being eligible for coverage under the Program as a “Dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the 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 death of the Retiree, commencement of a proceeding in bankruptcy, or enrollment of the Retiree 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 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 complete a Change in Status Form that can be obtained from by calling 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 of Record or Dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

How is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For example, both the Retiree and the Retiree's Spouse of Record may elect continuation coverage, or only one of them. Covered Retirees may elect COBRA continuation coverage on behalf of their Spouses of Record, 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 of Record 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 Retiree, enrollment of the 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.

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 or retirees. Continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. 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 Retiree contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage.

First Payment of Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form that you receive from 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 Retiree during COBRA Period

A child born to, adopted by or placed for adoption with a covered Retiree during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Retiree is a qualified beneficiary, the covered 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 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 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 Retiree's period of employment with the employer is entitled to the same rights under COBRA as a Dependent child of the covered Retiree, regardless of whether that child would otherwise be considered a Dependent.

Governmental Assistance from Trade Act of 2002

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

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

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

If You Have Questions

Questions about any of the Programs or your COBRA continuation coverage rights should be addressed to the Plan Administrator or Ceridian. For information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Program Informed of Address Changes

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

Section 13. Grievance Procedure

If you want to appeal the denial of a Claim, see *Claims Procedures* in APPENDIX B.

If you feel that your HMO or insured plan is discriminating against you or treating you unfairly, use the grievance procedure set forth in your HMO/insured plan brochure, or contact your HMO or insured plan.

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 Wrapper 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 14. Your Legal Rights Under ERISA

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 *Ending Coverage* section for more information.

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

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

Section 15. 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 Appendix B for information about the Claims Administrator's discretion.

Section 16. Welfare Benefits

Welfare benefits, such as the Union Carbide Retiree Insured Health Program for Pre-Medicare and Medicare Eligible Retirees, are not required to be guaranteed by a government agency.

Section 17. The Company's Right to Terminate or Amend the Program

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

Section 18. Disposition of Plan Assets If the Program is Terminated

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

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

Section 19. 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 20. 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 retiree medical budget is described in the *Premiums and Premium Cap* section of this SPD. Benefits are underwritten by the respective HMO's and Triple S. The Program is an insured plan under ERISA. Any assets of the Program may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program may be amended from time to time, as well as to pay 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 21. 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 22. For More Information

For more information regarding the provisions in this SPD Wrapper, please contact the Secova or the Plan Administrator. Contact information for Secova and the Plan Administrator can be found in Section 1 entitled *ERISA Information*. For information about benefits covered under a specific HMO or insured plan, or claims for HMO/insured plan benefits, contact the specific HMO.

APPENDIX A. Definitions of Terms

The following are some of the defined terms of Union Carbide Retiree Insured Health Program. Additional terms are defined in the Plan Document for the Program. Capitalized words refer to terms defined in this SPD Wrapper 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:

On or after August 1, 2003, a former Employee who receives a payment from a severance plan authorized by a Participating Employer or is a party to a written agreement signed by a Participating Employer is a "60 Point Retiree medical Severance Plan Participant" if both such Employee and an authorized representative of such Participating Employer signed a release or contract in which the Participating Employer states that such former Employee shall be eligible for coverage under the Program and if the following requirements are met:

1. The former Employee is younger than age 50 and has more than 10 years of Service on the date his employment with the Participating Employer ended, and
2. The former Employee has at least 60 Points on the date his employment with the Participating Employer ended, and
3. The former Employee was eligible for a plan under The Dow Chemical Company Medical Care Program or The Dow Chemical Company Insured Health Program (except the International Medical and Dental Plan) on the day preceding his termination of employment with the Participating Employer, and
4. The former Employee is vested under the Union Carbide Employees' Pension Plan, and
5. The former Employee's final active pension plan was Union Carbide Employees' Pension Plan, and
6. The former Employee is not eligible for coverage under another retiree medical plan or retiree medical support program sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates.

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 HMO. 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.

Attribution Schedule:

The applicable attribution schedule described in this SPD.

Bargained-for Employee:

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

Claim:

A written request by a claimant that is either a Claim for Plan Benefits or a Claim for an Eligibility Determination, as those terms are defined in this Summary Plan Description.

Claim for an Eligibility Determination:

A Claim requesting a determination as to whether a claimant is eligible to be a Participant of the Program. A Claim for an Eligibility Determination does not include a request for determination of eligibility under the Program’s COBRA provisions.

Claim for Plan Benefits:

A Claim requesting that the applicable HMO offered under the Program pay for benefits covered under such HMO.

Claims Administrator

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

COBRA

The federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) that allows a member or Dependent to stay enrolled in the Program for a limited time after coverage for that person would ordinarily cease. Some states have similar statutes that apply to the HMO or insured plans that do business in those states.

Company

Union Carbide Corporation, a subsidiary of The Dow Chemical Company.

Covered Person or Participant or Member

A Retiree, 60 Point Retiree Medical Severance Plan Participant, LTD Participant, Survivor, or a Dependent who is covered under the applicable HMO or insured plan, or a person who is continuing coverage under COBRA.

Creditable Coverage

Coverage under the Union Carbide Insured Health Program, including any of its underlying plans, an HMO, 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, if any.

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 26th birthday, may continue coverage.

Domestic Partner

A person who is a member of a Domestic Partnership.

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 Dow Chemical Company 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.

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

Domestic Partnership:

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

A.

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

B.

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

Dow

When used in this SPD Wrapper and other communications to Employees, “Dow” refers to The Dow Chemical Company and certain of its subsidiaries and affiliates.

Eligibility Determination Claims

Claims requesting a determination as to whether a claimant is eligible to be a Participant under the HMO or insured plan.

Eligibility Service:

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

Employee

A person who:

- prior to February 6, 2001, was employed by the Union Carbide Corporation or one of its subsidiaries that was authorized by it to participate in this Program;
- is employed by a Participating Employer to perform personal Services in an employer-Employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute;
- receives a payment for Services performed for the Participating Employer directly from UCC’s or The Dow Chemical Company’s U.S. Payroll Department, and
- is either a Salaried individual who is classified by the Participating Employer as having regular Full-Time status, a Salaried individual who is classified by the Participating Employer as having active Less-Than-Full-Time active status, or is a Bargained-for Individual who is classified by the Participating Employer as having regular Full-Time active status whose bargaining unit has agreed to the Program.
- if Localized, is Localized in the U.S..
- if on an international assignment, is either 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 Dow Chemical Company’s U.S. Payroll Department. Further, the definition of “Employee” does not include any individual who is characterized by the Participating Employer as an independent contractor, contingent worker, consultant or contractor. These individuals are not “Employees” (with a capital “E”) for purposes of the Plan even if such individual(s) is determined by a court or regulatory agency to be a “common law employee” of a Participating Employer.

Family:

The lives covered under the Retiree, Surviving Spouse of Record/Domestic Partner of Record, 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, 2001, 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.

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 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 UCC or a Participating Employer as having Full-Time status.

HIPAA

The Health Insurance Portability and Accountability Act.

HMO

Health Maintenance Organization.

Initial Claims Reviewer

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

Bargained-for Employee:

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

Less-Than-Full-Time

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

Localized:

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

LTD Participant:

A former Employee who is receiving a payment from a long term disability plan and 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) effective January 1, 2002, common law Spouses of UCC employees and former UCC employees who were covered under a UCC medical plan at any time between February 5, 2001 and December 31, 2001 as “spouses” of UCC employees will be deemed to be “Married” for purposes of the Program, and (b) the Plan recognizes a marriage that meets the requirements of Texas Family Code Annotated s. 2.402.

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. This is a government health insurance program for people 65 and older that is administered by the Social Security Administration (SSA). You may become eligible for Medicare prior to reaching age 65 if you are deemed by the SSA to be disabled. Medicare has two parts: Part A and Part B. Part A has no enrollment fee; Part B requires ongoing contributions, which are withheld from your monthly Social Security payments. In order to receive maximum benefits under MSP, you should enroll in both Part A and Part B of Medicare. You should apply for enrollment at least three months before you reach age 65, or earlier if disabled.

Medicare Advantage Plan:

An HMO that has been approved by the government as a “Medicare Advantage Plan with Prescription Drug Coverage” and is also offered under the Union Carbide Corporation Insured Health Program.

Medicare Eligible

Retirees and their Spouses of Record/Domestic Partners of Record who are age 65 or older or who are eligible for Medicare due to disability prior to age 65.

Medicare Modernization Act:

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

Medicare Part A

This part of Medicare covers many of the charges if you are a bed patient in a hospital or in an extended care facility, or at home receiving treatment from a home health agency. It covers such services as semi-private room and board, operating room, regular nursing care, x-rays, radiology and laboratory tests, and medical supplies and drugs furnished by the hospital. For the first 60 days in the hospital, Part A will pay all of your eligible

expenses except for a deductible (\$812 in 2002). Between the 61st and 150th day in the hospital, Part A will pay part of your expenses. It pays nothing after 150 days.

Medicare Part B

This part of Medicare covers expenses of surgery, physicians, and a number of other services and supplies. It pays 80 percent of specified charges after you pay an annual Part B deductible (\$100 in 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.

Medicare Supplement Plan (MSP)

The Medicare Supplement Plan of the Union Carbide Corporation Retiree Medical Care Program. Also referred to as MSP.

Participant

A Retiree, LTD Participant, 60 Point Retiree Medical Severance Plan Participant, or Survivor who is eligible to participate in the Program because he meets the eligibility requirements 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. Notwithstanding anything to the contrary, a “Participating Employer” is only a “Participating Employer” while it is a member of the Controlled Group. If the entity ceases to be a member of the Controlled Group, then the entity ceases to be a “Participation Employer” on the date it is no longer a member of the “Controlled Group”. “Controlled Group” is with respect to Union Carbide Corporation, and means a controlled group of corporations or entities within the meaning of section 414(b) or section 414(c) of the Code.

Plan

The HMO or insured product that provides coverage from the HMO or insurance carrier. There are many “Plans” offered through HMOs and insurance carriers under The Dow Chemical Company Insured/HMO Medical Program.

Points

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

Pre-Medicare Eligible

Retirees and their Spouses of Record/Domestic Partners of Record who are neither age 65 or older, nor disabled as determined by Social Security.

Program

Union Carbide Corporation Retiree Insured Health Program (formerly known as the Union Carbide Corporation Insured/HMO Medical Program for Pre-Medicare and Medicare Eligible Retirees).

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 Program's requirements by requesting a copy from the Plan Administrator (see the *ERISA* Section of this SPD Wrapper.)

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 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 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 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 UCC may subsidize retiree medical premiums. UCC may choose to subsidize retiree medical premiums below the Retiree Medical Budget.

Retiree Service Center

Retiree Service Center, c/o The Dow Chemical Company, Employee Development Center, Midland, MI 48674 (800) 344-0661 or (989) 636-0977.

RHCAP

The Dow Chemical Company Retirement Health Care Assistance Plan.

Salaried Individual

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

Service:

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

- a. 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.
- b. With respect to an 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.
- c. With respect to an 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:

A person who is Married to the Retiree, LTD Participant, or 60 Point Retiree Medical Severance Plan Participant. See the definition of Marriage for further details.

Spouse/Domestic Partner:

Refers to a Spouse or Domestic Partner, whichever is applicable.

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.

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

Spouse of Record/Domestic Partner of Record:

Refers to a Spouse of Record or Domestic Partner of Record, whichever is applicable.

Subrogation:

The substitution of one party (in this case, UCC) in place of an injured person, with respect to that person’s legal rights against a third party.

Summary Plan Description (“SPD”)

The summary plan description for the Program. The SPD is comprised of the SPD Wrapper, together with the material provided by the applicable HMO or insured plan, is intended to constitute the “Summary Plan Description” for the Program.

Surviving Spouse or Surviving Domestic Partner

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

Surviving Spouse of Record or Surviving Domestic Partner of Record

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

Survivor:

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

TDCC

The Dow Chemical Company

Termination of Domestic Partnership

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

UCC

Union Carbide Corporation, a subsidiary of The Dow Chemical Company.

UCEPP

UCEPP means the UCEPP component of the Union Carbide Employees' Pension Plan.

Union Carbide

Union Carbide Corporation and certain of its subsidiaries.

Union Carbide Insured/HMO Medical Program for Pre-Medicare and Medicare-Eligible Retirees

Former name of the Union Carbide Corporation Retiree Insured Health Program.

Union Carbide Retiree Medical Care

Union Carbide Corporation Retiree Medical Care Program. This self-insured program includes MAP Plus, and Catastrophic Medical and MSP Plans applicable to eligible Retirees.

Union Carbide Retiree Insured Health Program

Union Carbide Corporation Retiree Insured Health Program (Used interchangeably with "Union Carbide Corporation Insured Health Program", "Union Carbide Insured Health Program", and "UCC Insured Health Program").

Union Carbide Corporation

Union Carbide Corporation, a subsidiary of The Dow Chemical Company.

Union Carbide Employee's Pension Plan

Union Carbide Employees' Pension Plan, formerly known as the Retirement Program for Employees of Union Carbide Corporation and its Participating Subsidiaries.

APPENDIX B. Claims Procedures

These Claims procedures are part of Union Carbide Insured Health Program Summary Plan Description (SPD). They only address *Claims for an Eligibility Determination* (see definition). For *Claims for Plan Benefits*, see the information provided by your HMO or insured plan. If you no longer have a copy of the information provided by your HMO or insurance plan, contact your HMO or insurance plan. You may contact Retiree Services for assistance in obtaining the address of your HMO or insurance plan.

B.1 General

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

B.2 Deadline to File Your Claim

Your HMO may have established a deadline by which Claims must be filed. Check with your HMO.

B.3 Who Will Decide Whether to Approve or Deny My Claim?

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

Claims for an Eligibility Determination: The initial determination for a *Claim for an Eligibility Determination* is made by the Initial Claims Reviewer. The Initial Claims Reviewer is the 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 B.5 for how to file a *Claim for an Eligibility Determination*, or how to appeal a denial of eligibility to participate in the Plan.

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

Authority of Administrators and Your Rights Under ERISA

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

B.4 An Authorized Representative Can Act on Your Behalf

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

B.5 Claims for Benefits

Filing a Claim for Benefits

You must file a *Claim for Benefits* with your specific HMO or insured plan. You must follow your HMO or insured plan's claims procedures, which are contained in the information provided to you by your HMO or insured plan. If you no longer have a copy of the information provided by your HMO or insurance plan, contact your HMO or insurance plan. You may contact Secova for assistance in obtaining the address of your HMO or insurance plan. Contact information for Secova can be found in Section 1 entitled *ERISA Information*.

Appealing a Denial of a Claim for Benefits

If you want to appeal your HMO or insured plan's decision to deny your Claim for Benefits, you should follow the appeals procedures of your HMO or insured plan. These appeals procedures are contained in the information provided to you by your HMO or insured plan. If you no longer have a copy of the information provided by your HMO or insurance plan, contact your HMO or insurance plan. You may contact Secova for assistance in obtaining the address of your HMO or insurance plan. Contact information for Secova can be found in Section 1 entitled *ERISA Information*.

B.6 Eligibility Determination Claims

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

- the name of the person who is requesting an eligibility determination,
- the benefit plan for which the eligibility determination is being requested,
- the relationship of the person requesting eligibility determination in relation to the Retiree,
- documentation of such relationship,
- Retiree's Name, and
- Retiree's Dow ID number

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 Retiree Insured Health Program

Initial Determination

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

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

Appealing the Initial Determination

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

- your name,
- name of the Plan,
- reference to the initial determination,
- explanation of the reason why you are appealing the initial determination,
- Retiree's Name, and

- Retiree's Dow ID number

Appeals of eligibility determination Claims should be sent to:

Global Director of Benefits

The Dow Chemical Company

Employee Development Center

Midland, Michigan 48674

Attention: Appeals Administrator for Union Carbide Retiree Insured Health Program
(Appeal of Eligibility Determination)

You can submit any additional information to the Global Director of Benefits when you submit your request for appeal. You also may request that the Plan Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the 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 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.

Appendix C

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

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

- **Triple S Plan**
- **All health maintenance organizations (HMO's) participating in the Union Carbide Corporation Insured Health Program that are available for those who are not eligible for Medicare ("UCC-approved HMO's")**
- **All HMO's participating in the Union Carbide Corporation Insured Health Program that are available for those who are eligible for Medicare ("Medicare Advantage - D Plans"). These HMO's have entered into contracts with Medicare to provide Medicare benefits, and are thus Medicare plans.**

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

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

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. The Dow Chemical Company has determined that the prescription drug coverage offered by the all UCC participating HMOs are on average for all plan**

participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Dow coverage, be aware that you and your dependents will be able to get this coverage back during The Dow Chemical Company annual enrollment period. If you were enrolled in the Old Plan or New Plan, you may not re-enroll in either the Old Plan or the New Plan unless you were enrolled in a Dow approved Medicare Advantage-PD (an HMO) that provides prescription drug coverage. Check the applicable summary plan description for details.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be

at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	Fall, 2010
Name of Entity/Sender:	The Dow Chemical Company
Contact--Position/Office:	U.S. Benefits Center
Address:	Employee Development Center Midland, MI 48674
Phone Number:	(800)-344-0661 or (989) 636-0977