Summary Plan Description for:

The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan

ERISA Plan # 502

Effective January 1, 2019 and thereafter until superseded

This Summary Plan Description (SPD) supersedes all prior versions of this SPD.

Copies of updated SPDs (including this SPD) are available at the Dow Benefits & Well-being website (www.dowbenefits.com), by requesting a copy from HR Solutions (+1 (833) 693-6947 (USA)), or by submitting your request through the Dow Benefits website's Message Center (http://dowbenefits.ehr.com).

SPDs in languages other than English may be available through a local server or Intranet site. In the case of any conflict, the English version of the Plan Document, SPD and insurance policy shall prevail over any other language version.

Summaries of material modifications may also be published from time to time in separate documents.

Content Steward: Gerisch
January 1, 2019
Lit #318-60510
DC: 7048763-18

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Section 1. ERISA Information

Business Travel Accident and Occupational Accident Insurance Plan	
Type of Plan	Accident insurance
Type of Plan Administration	Insurer administration
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 +1 (833) 693-6947 (USA)
Employer Identification Number	38-1285128
Plan Number	502
Plan Administrator	The Plan Administrator is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Documents. The person, group of persons, or entity designated as Plan Administrator is listed in *Appendix C. Named Fiduciaries*. The address and phone number for the Plan Administrator are: The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Plan Administrator for BTA/OAI Plan +1 (833) 693-6947 (USA)
Group Policy Number	GTP-9037918A
Claims Administrator for Claims for Plan Benefits	National Union Fire Insurance Company of Pittsburgh PA (NUFIC), an AIG company. NUFIC Accident and Health Claims Division P. O. Box 25987 Shawnee Mission, KS 66225-5987 1-800-551-0824
Claims Administrator for a Claim for an Eligibility Determination	The Claims Administrator for a Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Documents. The person, group of persons, or entity designated as Claims Administrators for a Claim for an Eligibility Determination is listed in *Appendix C. Named Fiduciaries*. The address and phone number for the Claims Administrators for a Claim for an Eligibility Determination are: *Initial Claims Reviewer:* The Dow Chemical Company North America Benefits

	P.O. Box 2169 Midland, MI 48641 Attention: Initial Claims Reviewer for the BTA/OAI Plan (Eligibility Determination) +1 (833) 693-6947 (USA) *Appeals Administrator:* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Appeals Administrator for the BTA/OAI Plan (Eligibility Determination) +1 (833) 693-6947 (USA)
To Serve Legal Process	BTA/OAI Plan Administrator at the above address or: The Dow Chemical Company General Counsel Corporate Legal Department 2211 H.H. Dow Way Midland, MI 48674
Plan Year	The Plan's fiscal records are kept on a plan year beginning January 1 and ending on December 31 of each year.
Funding	Dow pays the entire premium for Plan coverage under the Plan. Benefits under the Plan are insured through a group insurance contract with National Union Fire Insurance Company of Pittsburgh PA (NUFIC). Benefits, if any, that are not paid through a group insurance contract are paid from the Company's or Participating Employer's general assets. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from assets of the Plan, if any.

Section 2. Introduction

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan (the "Plan" or "BTA/OAI").

The Plan is governed by the plan document for the Plan, which is the legal instrument under which the Plan is operated. This legal instrument is referred to in this SPD as the "Plan Document." If there is any inconsistency between this SPD and the Plan Document, the Plan Document shall govern. You may request a copy of the Plan Document from the Plan Administrator.

This SPD contains important information about your benefits under the Plan. However, it does not contain all of the information that may pertain to your benefits. Further information can be found in the Plan Document for the Plan and the group insurance policy that underwrites the benefits provided under the Plan (the "Policy"). If there is an inconsistency between this SPD and the Policy, the Policy will govern.

The Dow Chemical Company reserves the right to amend, modify or terminate the Plan at any time in its sole discretion.

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

Capitalized words in this SPD are defined either in the Plan Document or in *Appendix A. Definitions of Terms*. References in this SPD to the "Company" mean The Dow Chemical Company, and references to "Participating Employer" or "Dow" mean the Company or any other corporation or business entity the Company authorizes to participate in the Plan. 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. Provisions Applicable to the Business Travel Accident, Occupational Accident Insurance, and Travel Accident Components of the Plan

3.1. Eligibility

As an active Employee of Dow, you are eligible for coverage under the Plan on your first day of work for Dow. You are also eligible for coverage if you are receiving partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008). For eligibility during a Leave of Absence, see Section 4.3.1. and Section 5.3.1. .

Sections 4 and 5 do not apply to Inbound and Outbound Employees. Section 6 applies only to Inbound and Outbound Employees.

3.2. Enrollment

Enrollment is automatic.

3.3. Contributions

You pay no premiums for Plan insurance. Dow pays the entire premium.

3.4. Coverage Provisions

Benefits are paid when loss of life, Total and Permanent Disability, or serious injury as listed in the table below, occur as the result of a covered accidental injury and within 365 days of such injury. Benefits are paid in U.S. dollars.[1] The U.S. dollar amount is based on the percentage of Principal Sum payable and, if applicable, your Annual Base Salary, determined as of the date of the covered accident. The Principal Sum is the amount determined under Section 4.3.3. , Section 5.3.2. , or Section 6.2.2. , whichever is applicable. The percentage of the Principal Sum is determined in accordance with Section 3.4.1. (Table of Losses). If you are paid in a currency other than U.S. dollars, your Annual Base Salary will be converted to U.S. dollars using the currency exchange rate in effect as of the date of the covered accident. If you are on an expatriate assignment, the U.S. dollar amount is based on the percentage of Principal Sum payable, and, if applicable, the Annual Base Salary in home-country currency and the currency exchange rate, determined as of the date of the covered accident. The home-country Annual Base Salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

Please note that if a benefit is payable for a loss suffered by an Insured Person whose permanent, current place of primary residence is outside the U.S. or Canada, NUFIC will

[1] If a benefit cannot be paid in U.S. dollars due to local laws, the benefit will be paid by the Participating Employer in local currency so as to comply with applicable law. Such payment will be converted to local currency using the exchange rate in effect at the payor bank designated by the Participating Employer on the date the payment is issued to the beneficiary. By a separate agreement between the Plan Sponsor and the insurance carrier, the Participating Employer will then be reimbursed by the insurance company.

pay the benefits to the Participating Employer, and the Participating Employer will transmit such benefits (reduced as described later in this paragraph) to the Insured Person or the Insured Person's beneficiary. ***If the Participating Employer must pay a tax in connection with the transmittal of such benefits, the amount of the benefit payable to the Insured Person or the Insured Person's beneficiary will be reduced by the amount of taxes that the Participating Employer must pay.***

3.4.1. Table of Losses

	Percentage of Principal Sum:
Loss of:	
Life	100%
Both hands or both feet	100%
Total sight of both eyes	100%
One hand and one foot	100%
One hand and the total sight of one eye	100%
One foot and the total sight of one eye	100%
Speech and Hearing in both ears	100%
Speech or Hearing in both ears	50%
One hand or one foot	50%
Total sight of one eye	50%
Hearing in one ear	25%
Thumb and Index Finger of Same Hand	25%
Paralysis	
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%
Coma	1% per month for 100 months or until the coma ends
Severe Burn:	
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint (Right)	22.5%
Hand and Forearm Below Elbow Joint (Left)	22.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Right)	13.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Left)	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints (Front)	36%
Torso Below Neck to Shoulder Joints and Hip Joints (Back)	36%
Thigh Below Hip Joint to Knee Joint (Right)	9%
Thigh Below Hip Joint to Knee Joint (Left)	9%
Foot and Lower Leg Below Knee Joint (Right)	27%
Foot and Lower Leg Below Knee Joint (Left)	27%
Permanent Total Disability	100%

3.4.2. Coma. If you should fall into a coma lasting at least 31 consecutive days within 365 days of a covered accidental injury, the applicable Plan will pay a monthly benefit until either the coma ends, you die, or 100 months have passed, whichever occurs first. The monthly benefit equals 1% of the Principal Sum, less any other amount paid or payable under the Policy as a result of the same accident.

3.4.3. Exposure. If by reason of an accident, you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable under this Plan, the loss will be covered under this Plan.

3.4.4. Disappearance. If your body has not been found within one year of your disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which you were an occupant, then it shall be deemed, subject to all other terms and provisions of the Plan, that you have suffered a loss of life within the meaning of the Plan.

3.4.5. Exclusions. The Plan does not cover any loss caused in whole or in part by, or contributed to by, or as a natural and probable consequence of, any of the following excluded risks, even if the proximate or precipitating cause of the loss is an accidental bodily injury:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition.
- Sickness, disease, mental incapacity, or bodily infirmity, whether the loss results directly or indirectly from any of these.
- Death or injury caused by the Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.
- Death or injury that occurs while on vacation during a business trip.
- In some cases, death or injury in connection with vehicles used for aerial navigation. For example, there may be exclusions for death or injury that occurs while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers or while participating in a Specialized Aviation Activity (see *Appendix A. Definitions of Terms*).
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
- The Insured Person's commission of or attempt to commit a felony.

3.4.6. Multiple Losses. If you have more than one loss from a single accident, only one benefit amount is payable. It will be for the one loss that provides you the largest percentage of the Principal Sum.

3.4.7. Paralysis. The Plan pays a benefit for complete and irreversible paralysis that occurs within 365 days as a result of an injury caused by a covered accident.

3.4.8. Permanent Total Disability. You are considered to be Totally and Permanently Disabled when you are not able to engage in any occupation or employment for pay or profit for which you are reasonably qualified based on your education, training or experience.

You are eligible for a benefit when your Total and Permanent Disability is caused by a covered accidental injury and begins within 365 days of the date of that accidental injury. Your disability must have continued for 12 consecutive months and be total, continuous and permanent at the end of that one-year period.

When you meet these requirements, the applicable Plan will provide the Benefit Payable, as outlined in the preceding table. If you have more than one loss from a single accident, only one benefit amount is payable — the one that provides you with the largest percentage of the Principal Sum.

The Plan does not pay benefits if your Spouse, Domestic Partner, or Dependent Child becomes totally and permanently disabled.

3.4.9. Rehabilitation Benefit. If you suffer a covered accidental dismemberment or paralysis, the applicable Plan will reimburse up to US$25,000 of Covered Rehabilitative Expenses that are incurred within two years of the covered accident. The rehabilitation services must be Medically Necessary as determined by a Physician and the expenses cannot exceed the usual level of charges in your location. Charges that would not have been made if no insurance existed are not payable. In addition to the exclusions listed above, Covered Rehabilitative Expenses do not include any expenses payable by Workers' Compensation or other similar law.

3.4.10. Seat Belt and Air Bag Benefits. If you die in a covered accident while riding or driving an Automobile (as defined in the Policy) and while you were properly wearing an original, factory-installed seat belt, a seat belt benefit in an amount of up to 10% of the Principal Sum, to a maximum of US$50,000 is payable. If a seat belt benefit is payable and if you were positioned in a seat protected by a properly functioning, original factory-installed Supplemental Restraint System (as defined in the Policy) that inflates on impact, an additional air bag benefit in an amount of up to 10% of the Principal Sum, to a maximum of US$50,000 is payable.

Verification of the actual use of the seat belt at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact, must be part of an official report of the accident or be certified in writing by the investigating officer(s).

3.4.11. Severe Burns. If you are Severely Burned in a covered accident and 100% of the surface of the Specified Body Area is Severely Burned, the benefit payable is 100% of the maximum percentage of the Principal Sum listed above. If a lesser proportion of the Specified Body Area is Severely Burned, the benefit payable is that same lesser proportion of the maximum percentage of the Principal Sum. For example, the maximum percentage for "foot and lower leg below knee joint" is 27%. If 100% of that area is Severely Burned, the benefit payable is 100% of 27% of the Principal Sum. If 50% of the area is Severely Burned, the benefit payable is 50% of 27%, or 13.5% of the Principal Sum.

If more than one Specified Body Area is Severely Burned as a result of the same accident, the benefit payable is the lesser of (1) the sum of the benefit amounts calculated separately, or (2) 100% of the Principal Sum.

The determination of whether or not a Specified Body Area is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Physician. The Claims Administrator has a right, at its own expense, to have the determination verified by a Physician of its choice.

3.4.12. War Risk. The Plan covers losses sustained while you are on business for Dow and, for the BTA component, losses sustained by your Spouse or Domestic Partner and/or Dependent Children, under the circumstances described in the Policy, that are caused by or resulting from declared or undeclared war occurring within the geographic limits or territorial waters of, or airspace above, certain locations in the world covered under the Policy. Currently, this coverage is provided only in Afghanistan, Iraq, and Syria, but you are not covered for losses caused by or resulting from war under the Policy or Plan if the loss occurs in your country of permanent residence. If you travel to Afghanistan, Iraq, or Syria, you are required to notify the Plan Administrator PRIOR to your travel there in order to be covered under the Plan for losses caused by or resulting from declared or undeclared war occurring in one of these countries.

3.4.13. Weekly Accident Indemnity. You may be eligible for a benefit when a continuous total disability is caused by an injury sustained in an accident while riding as a passenger, pilot, operator, or crew member in a Company-owned aircraft and your continuous total disability begins within 30 days of the date of the accidental injury. The amount of the benefit is US$200 per week, accrued and payable on a biweekly basis. The benefit is payable for the period during which you are continuously and totally disabled, for up to 52 weeks after the date of the accident. The disability must be total and continuous such that it prevents you from performing any and every duty pertaining to your occupation for the Company, and you must be under the care of a legally qualified physician during the disability period. If you are totally disabled for less than a full week, benefits will be calculated at a rate of $1/7^{th}$ of the weekly benefit for each day of total disability after the first day of total disability. Your Spouse, Domestic Partner, or Dependent Child are not eligible for this benefit.

3.4.14. Repatriation of Remains. If you, or for the BTA component, your Spouse or Domestic Partner, or Dependent Child die due to an accidental injury covered by this Plan or an emergency sickness (as defined in the Policy) and the accidental

injury or emergency sickness occurs while outside a 100 mile (161 km) radius of your current primary residence, the Plan will pay for covered expenses reasonably incurred to return the decedent's body to the current place of primary residence, up to a maximum of $1,000,000. Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffin or receptacle adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

The Insured Person's beneficiary must contact International SOS in advance for this benefit to be payable. International SOS can be reached at the International SOS Philadelphia Assistance Center, phone number 1-215-942-8226.

3.4.15. Home Alteration and Vehicle Modification Benefit. If you (1) suffer an accidental dismemberment or paralysis for which an accidental dismemberment and paralysis benefit is payable; (2) did not, prior to the date of the accident causing the loss(es), require the use of a wheelchair to be ambulatory; and (3) as a direct result of such loss(es) are now required to use a wheelchair to be ambulatory; the Plan will pay Covered Home Alteration and Vehicle Modification Expenses (as defined in the Policy) that are incurred within one year after the date of the accident causing the loss(es), up to a maximum of $25,000 for all such losses caused by the accident.

3.5. Beneficiaries

3.5.1. Employees Covered by a Company-Provided Life Insurance Policy. If you are covered under a life insurance policy for which Dow pays the premium ("life insurance policy"), including if you are a not a United States citizen, death benefits will be paid to whomever you have named as beneficiary or beneficiaries of the life insurance policy unless you have made a separate BTA/OAI designation. If you do not have a designated beneficiary, your beneficiaries are (1) your Spouse/Domestic Partner, (2) if you have no surviving Spouse/Domestic Partner, your Children, (3) if you have neither Spouse/Domestic Partner nor the Children surviving, your parents, or (4) if you have no parents surviving, your brothers and sisters or (5) if you have no Spouse/Domestic Partner, children, parents or brothers and sisters surviving, your estate.

3.5.2. Employees with No Company-Provided Life Insurance. If you are not covered by a "life insurance policy" for which Dow pays the premium, and you do not have a designated beneficiary on file for BTA/OAI, your beneficiaries are (1) your Spouse/Domestic Partner, (2) if you have no surviving Spouse/Domestic Partner, your Children, or (3) if you have neither Spouse/Domestic Partner nor the Children surviving, your parents, or (4) if you have no parents surviving, your brothers and sisters or (5) if you have no Spouse/Domestic Partner, children, parents or brothers and sisters surviving, your estate.

3.6. Filing a Claim or Appealing a Denial of a Claim.

If you are injured in an accident and suffer a covered loss, you or your beneficiary must file a written claim in order to apply for a benefit. To initiate a claim, see *Appendix B. Claims Procedures*.

3.7. Payment of Unauthorized Benefits.

If the Plan Administrator determines that benefits in excess of the amount authorized under the Plan were provided to, or on behalf of, a Participant, Dependent, beneficiary, or other person (for example, because benefits were paid even though the individual did not meet applicable eligibility requirements or because the wrong beneficiary was paid):

- The amount of any other benefit paid to, or on behalf of, such Participant, Dependent, beneficiary, or other person under the Plan may be reduced by the amount of the excess payment.

- The Plan Administrator may require the Participant, Dependent, beneficiary, or other person to reimburse the Plan for benefits paid, including reasonable interest.

- If the person does not reimburse the Plan by the date determined by the Plan Administrator, the Plan Administrator may cancel coverage for the Participant and refuse re-enrollment.

- The Plan Administrator may elect recoupment or reimbursement, regardless of whether the person who received the excess benefit was a Participant or beneficiary entitled to receive benefits, and regardless of whether the excess benefit was provided by reason of the Plan Administrator's error or by reason of false, misleading, or inaccurate information furnished by the Participant, beneficiary, or any other person.

For excess payments to beneficiaries, the Plan Administrator may elect to pursue any of the above remedies directly against the Participant or his or her estate.

3.8. Fraud Against the Plan.

If you intentionally misrepresent information to the Plan or NUFIC, knowingly withhold relevant information from the Plan or NUFIC, or deceive or mislead the Plan or NUFIC, the Plan Administrator may (1) terminate your participation in the Plan and your coverage, retroactively from the date deemed appropriate by the Plan Administrator, or prospectively; (2) require you to reimburse the Plan for amounts paid to you or your beneficiary, including all costs of collection such as attorneys' fees and court costs; and/or (3) prohibit you from enrolling in the Plan or determine that you are not eligible for coverage under the Plan. In addition, your employer may terminate your employment, pursue civil and/or criminal action against you, or take other legal action. If you are terminated from eligibility under any benefit plan sponsored by Dow or a Dow affiliate because of a violation of a similar section of that benefit plan, the Plan Administrator may determine that you are not eligible for coverage under the Plan.

3.9. Your Legal Rights under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan,

including insurance contracts and collective bargaining agreements (if applicable), the Plan Document, and the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. For more information regarding enforcing your rights in court, see Section 3.14 of this SPD regarding litigation and class action lawsuits.

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

3.10. Plan Administrator's Discretion

The Plan Administrator is the person, group of persons or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons or entity designated as the Plan Administrator is listed in *Appendix C. Named Fiduciaries*. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document and *Appendix B. Claims Procedures*.

3.11. Plan Document

The Plan will be administered in accordance with its terms. If the VPHR determines that the applicable Plan Document or this SPD has a drafting error (sometimes called a "scrivener's error"), the applicable Plan Document or SPD will be applied and interpreted without regard to that error. The determination of whether there is a scrivener's error, and how to apply and interpret the Plan in the event of a scrivener's error, will be made by the VPHR, in the exercise of his or her best judgment and sole discretion, based on his or her understanding of the Company's intent in establishing the Plan and taking into account all evidence (written and oral) that he or she deems appropriate or helpful.

3.12. No Government Guarantee of Welfare Benefits

Welfare benefits, such as the benefits provided by the Plan, are not required to be guaranteed by a government agency.

3.13. Amendment, Modification, or Termination of Plan.

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

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

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

3.14. Litigation and Class Action Lawsuits

3.14.1. Litigation. If you wish to file a lawsuit against the Plan (a) to recover benefits you believe are due to you under the terms of the Plan or any law; (b) to clarify your

right to future benefits under the Plan; (c) to enforce your rights under the Plan; or (d) to seek a remedy, ruling or judgment of any kind against the Plan or the Plan fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Plan, you may not file a lawsuit until you have exhausted the claims procedures described in *Appendix B. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA.

The Applicable Limitations Period is the period ending one year after:

- in the case of a claim or action to recover benefits allegedly due to you under the terms of the Plan or to clarify your right to future benefits under the terms of the Plan, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Plan first repudiated its alleged obligation to provide such benefits;

- in the case of a claim or action to enforce an alleged right under the Plan (other than a claim or action to recover benefits), the date the Plan first denied your request to exercise such right; or

- in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

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

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

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

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

the jurisdiction in which the largest number of class members is reasonably believed to reside).

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

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

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

3.15. Funding

The Plan is partially funded by insurance underwritten by NUFIC, and partially funded by the general assets of the Participating Employer. With respect to all Claims payable to Participants or their beneficiaries in countries where NUFIC is permitted under the laws of such countries to pay such Claims, the Plan is fully funded by insurance under NUFIC policy number GTP-9037918A. With respect to Claims payable to Participants or their beneficiaries residing outside the U.S. or Canada, the Plan is funded by the general assets of the applicable Participating Employer.

3.16. Privilege

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

- the Advisor's client is the Advisee and not any Employee, Participant, Dependent, beneficiary, claimant, or other person;
- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and
- no Employee, Participant, Dependent, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his or her Advisors with respect to whom a privilege applies, unless mandated by a court order.

3.17. Waiver

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

3.18. Notices

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

3.19. No Assignment of Benefits

Except as otherwise provided in the Plan Document or an applicable Incorporated Document, or to the extent permitted or required by law, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge of any kind.

3.20. Uncashed Checks

Benefit payments made by check that is not cashed or deposited, or by electronic funds transfer or other payment method that is not deposited (for example, because the Participant cannot be located), shall remain in the Company's general assets, and shall not escheat to the state. Unless the Plan Administrator determines in its sole discretion that there are extenuating circumstances or except as provided otherwise in an applicable Incorporated Document, the Plan's obligation to pay the benefit shall be extinguished if the check is not cashed or deposited, or electronic funds transfer or other payment is not deposited, within one (1) year after the date of the check, transfer, or other payment method. Any benefits to which the check, electronic funds transfer, or other payment method relates will be forfeited.

The Administrator is entitled to rely on the last address provided to the Plan by the Participant, and has no obligation to search for or ascertain a Participant's whereabouts.

3.21. Tax Consequences of Coverage and Benefits

Neither the Company, nor any other Participating Employer or any other affiliate, makes any assertion or warranty about (1) services and supplies that a Participant obtains, or obtains reimbursement for, as Plan benefits; or (2) whether any taxes are required by any government or government agency to be withheld from, or paid with respect to, amounts paid under the Plan. The Participant shall bear all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

3.22. For More Information

If you have questions, contact HR Solutions at +1 (833) 693-6947 (USA).

IMPORTANT NOTE

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Business Travel Accident Plan and Occupational Accident Insurance Plan ("Plan"). However, this booklet is not all-inclusive and it is not intended to take the place of the Plan Document. In case of any conflict between this SPD and the applicable Plan Document, the applicable Plan Document will govern.

The Dow Chemical Company reserves the right to amend, modify or terminate the Plan (including amending the Plan Document and the SPD) at any time in its sole discretion.

The Plan Document is available for your review upon written request to the Plan Administrator. The SPD and the Plan do not constitute a contract of employment. Your employer retains the right to terminate your employment or otherwise deal with your employment as if this SPD and the Plan had never existed.

Section 4. Provisions Applicable Only to Business Travel Accident Coverage

Inbound and Outbound Employees are not eligible for Business Travel Accident Insurance benefits in this Section 4. Inbound and Outbound Employees are eligible for Travel Accident benefits in Section 6.

4.1. Non-Duplication of Benefits

The Business Travel Accident Insurance (BTA) component of the Plan is designed to provide personal injury accident coverage to eligible Employees while traveling on Dow business. The benefits and coverage provided by the BTA component of the Plan and the Occupational Accident Insurance (OAI) component of the Plan are intended not to duplicate each other. Therefore, if an accidental death, injury, or disability covered under the BTA component also is covered under OAI component, no benefits will be paid from the OAI component of the Plan.

4.2. Dependent Eligibility

Spouses or Domestic Partners and/or Dependent Children are covered when they incur a qualifying injury during travel that is sponsored, approved, and paid for by Dow.

4.3. Coverage Provisions

4.3.1. Periods of Coverage. The BTA component of the Plan covers you any time you are away from your normal work location while traveling on Dow business. You must be on Dow business and traveling at the direction of Dow to further Dow business in order to be covered. You are not covered during normal commuting to and from work or during periods of vacation even when the vacation occurs in between periods of business during a business trip.

BTA coverage becomes effective the minute you leave for a business trip. Whether you leave from your home or from your work location, coverage starts from whichever you leave *last.* The coverage is continuous, except for vacation periods, until you return to your home or work location, whichever you reach *first*.

BTA coverage ends on the day you Retire, begin receiving payments for "full disability" or "total disability" under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008) (the "LTD Plan"), begin a leave of absence, or terminate employment with a Participating Employer. However, BTA coverage continues while you are receiving partial disability payments under the LTD Plan.

4.3.2. Dependent Coverage. Your Spouse or Domestic Partner and Dependent Child(ren) are covered under the BTA component of the Plan if they incur a qualifying injury during travel that is sponsored by Dow. This may be the case when you relocate your family due to a job change. Your Spouse or Domestic Partner is covered for 50 percent of your Principal Sum up to a maximum of US$100,000. Each Dependent Child is covered for 25 percent of your Principal Sum up to a maximum of US$50,000.

Coverage for your Spouse or Domestic Partner ends at the same time as your coverage ends or, if earlier, on the effective date of a divorce or Termination of Domestic Partnership. Coverage for your Dependent Child ends at the same time as your coverage ends or, if earlier, on the date the eligibility requirements for this Plan are no longer met.

4.3.3. Principal Sum. The Principal Sum for the BTA component of the Plan is five times the U.S. dollar equivalent of your Annual Base Salary, up to a maximum of US$2 million. If you are paid in a currency other than U.S. dollars, your Annual Base Salary will be converted to U.S. dollars using the currency exchange rate in effect as of the date of the covered accident. If you are on an expatriate assignment and are being paid in host-country currency, the U.S. dollar amount is based on the percentage of Principal Sum payable, the Annual Base Salary in home-country currency and the currency exchange rate in effect on the date of the accident. The home-country Annual Base Salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

4.3.4. Multiple Losses. If you have more than one loss from a single accident, only one benefit amount is payable. It will be the amount of the one loss that provides you the largest percentage of the Principal Sum. This rule also applies to each covered family member.

4.4. Beneficiaries

If your Spouse or Domestic Partner and/or Dependent Child die in a covered accident, you as the Employee are the beneficiary. If you are not a survivor, the beneficiary is your estate or, at the option of the insurer, your surviving Spouse/Domestic Partner. The latter could occur, for instance, if you and a Dependent Child die in a covered accident but your Spouse or Domestic Partner survives.

Section 5. Provisions Applicable Only to Occupational Accident Insurance Coverage

Inbound and Outbound Employees are not eligible for the Occupational Accident Insurance benefits in this Section 5. Inbound and Outbound Employees are eligible for Travel Accident benefits in Section 6.

5.1. Non-Duplication of Benefits

The benefits and coverage provided by the Business Travel Accident (BTA) and the Occupational Accident Insurance (OAI) components of the Plan are intended not to duplicate each other. Therefore, if an accidental death, injury or disability covered under the BTA component also is covered under the OAI component, no benefits will be paid from the OAI component of the Plan.

5.2. Dependent Eligibility

There is no Dependent Coverage under the OAI component of the Plan.

5.3. Coverage Provisions

5.3.1. Periods of Coverage. The OAI component covers you while performing any assigned occupational duties for which Dow compensates you, while you are On-Premises of Dow. It becomes effective when you arrive at your work site and ends when you leave your work site. If you normally work from your home, you are covered if you are working on Dow business for which you will be compensated at the time of the accident.

You are not covered while commuting to and from work, during periods of vacation or other absences from work, or while traveling on company business.

OAI coverage ends on the day you Retire, begin receiving payments for "full disability" or "total disability" under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008) (the "LTD Plan"), begin a leave of absence, or terminate employment with a Participating Employer. However, OAI coverage continues while you are receiving partial disability payments under the LTD Plan.

5.3.2. Principal Sum. The Principal Sum for the OAI component of the Plan is four times your Annual Base Salary up to a maximum of US$1 million, subject to the aggregate limit. If you are paid in a currency other than U.S. dollars, your Annual Base Salary will be converted to U.S. dollars using the currency exchange rate in effect on the date of the accident. If you are on an expatriate assignment and are being paid in host-country currency, the U.S. dollar amount is based on the percentage of Principal Sum payable, the Annual Base Salary in home-country currency and the currency exchange rate in effect on the date of the accident. The home-country Annual Base Salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

5.3.3. Benefit Limits. The individual benefit limit for any one accident is US$1 million. The aggregate benefit limit for any one accident is US$100 million. This means if several Employees suffer losses in the same accident, the Plan will not pay more than US$100 million to all employees combined. The benefit amount will be allocated proportionately among the beneficiaries.

Section 6. Provisions Applicable Only to Travel Accident Coverage (Inbound and Outbound Employees Only)

This Section 6 applies only to Inbound and Outbound Employees.

6.1. Dependent Eligibility

There is no Dependent Coverage under the Travel Accident component of the Plan.

6.2. Coverage Provisions

6.2.1. Periods of Coverage. The Travel Accident component of the Plan covers you any time you are away from your normal work location regardless of whether you are traveling on Dow business or for pleasure. You are not covered during normal commuting to and from work.

Travel Accident coverage becomes effective the minute you leave for a trip. Whether you leave from your home or from your work location, coverage starts from whichever you leave *last.* The coverage is continuous until you return to your home or work location, whichever you reach *first*.

Travel Accident coverage ends on the day you Retire, begin receiving payments for "full disability" or "total disability" under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008) (the "LTD Plan"), begin a leave of absence, or terminate employment with a Participating Employer. However, Travel Accident coverage continues while you are receiving partial disability payments under the LTD Plan.

6.2.2. Principal Sum. For Inbound and Outbound Employees, the Principal Sum for the Travel Accident component of the Plan is US$400,000.

6.2.3. Multiple Losses. If you have more than one loss from a single accident, only one benefit amount is payable. It will be the amount of the one loss that provides you the largest percentage of the Principal Sum.

Appendix A. Definitions of Terms

The following are some of the defined terms of the Plan. Additional terms are defined in the Plan Document or the Policy. In case of conflict between this SPD and the Plan Document, the Plan Document will govern.

Annual Base Salary means an Employee's base monthly salary (or for an hourly paid employee, the base hourly rate) multiplied by the number of months or hours comprising the Employee's regular annual compensation schedule, including added monthly pays that are appropriate to the employer's pay system.

For Employees classified as having Part-Time or Less-Than-Full-Time status by the Company, Annual Base Salary shall be defined as follows:

(A) for Employees who have a defined work schedule, the Annual Base Salary shall be computed by multiplying the hourly rate in effect at the time of loss times the number of hours in the Employee's work schedule;

(B) for Employees who do not have defined work schedule, the Annual Base Salary shall be computed by multiplying the hourly rate in effect at the time of loss times the number of hours in the previous year, or 1040 hours, whichever is greater. If no previous year's record exists, such hourly rate shall be multiplied by 1040 hours.

Appeals Administrator means, with respect to reviewing an adverse Claim for Plan Benefits, NUFIC. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Appeals Administrator for Claims for an Eligibility Determination is listed in *Appendix C. Named Fiduciaries*.

BTA means the Business Travel Accident Insurance component of the Plan.

BTA/OAI Claims Processor means a function within HR Solutions that performs the clerical tasks associated with helping Plan participants file a Claim for Plan Benefits. The VGA Claims Processor is not a named Plan fiduciary.

Claim means a written request by a claimant for a Plan benefit or for an eligibility determination that contains at a minimum, the information described in *Appendix B. Claims Procedures*.

Claim for an Eligibility Determination means a Claim requesting a determination as to whether a claimant is eligible to participate under the Plan or as to the amount a claimant must contribute towards the cost of coverage.

Claim for Plan Benefits means a Claim requesting that the Plan pay for benefits covered under the Plan.

Claims Administrator means either the Initial Claims Reviewer or the Appeals Administrator, depending on the context in which the term is used.

Code means the United States Internal Revenue Code of 1986, as amended.

Coma means a profound state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation as determined by a licensed physician.

Company means The Dow Chemical Company, except that within the context of the NUFIC insurance policy and its riders and certificates, "company" means National Union Fire Insurance Company of Pittsburgh PA (NUFIC).

Dependent means an Employee's Spouse, Domestic Partner, or Dependent Child(ren).

Dependent Child(ren) means an unmarried child who is principally supported by the Participant and is the Participant's natural child from the moment of birth; legally adopted child; step-child; or foster child, each from the moment of placement in the home.

Coverage (under BTA) for a Dependent Child who meets the above criteria continues until the Dependent Child's 19th birthday, provided that coverage may continue after the child's 19th birthday as follows:

- A Dependent Child who is a full-time student at an accredited institution of higher learning on a full-time basis is eligible until his or her 26th birthday.

- A Dependent Child who is physically or mentally incapable of self-support upon attaining 19 years of age may continue coverage under the Plan until the later of: (i) the date he or she is no longer incapacitated, or (ii) the Participant is are no longer covered by the Plan. Proof may be required by the Plan of the Dependent Child's physical or mental incapacity. Contact HR Solutions at least 60 days before the Dependent Child's birthday if this applies to you.

Domestic Partner means a person who is a member of a Domestic Partnership with an Employee. A "Domestic Partnership" means, for all determinations made on or after January 1, 2019, a relationship between two people that meets all of the requirements of paragraph A, or the requirements of paragraph B, below. In addition, both people must sign a statement, acceptable to the Plan Administrator, certifying that the requirements of paragraph A or paragraph B, as applicable, have been met; the statement must be provided to the Plan Administrator; and there must have been no change in circumstances that would render such statement invalid as of the determination date.

A. Facts and Circumstances Test

1. The two people live together on the determination date;

2. The two people are not Married to other persons ;

3. The two people are each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely;

4. Both people are legally competent and able to enter into a contract;

5. The two people are not related to each other in a way which would prohibit legal Marriage;

6. In entering the relationship with each other, neither of the two people is acting fraudulently or under duress; and

7. The two people have been and are financially interdependent with each other and have submitted proof acceptable to the Plan Administrator of such financial interdependence.

B. Civil Union Test

Evidence satisfactory to the Plan Administrator is provided that the two people are registered as domestic partners, or partners in a civil union in a state or municipality or country that legally recognizes such domestic partnerships or civil unions.

The Plan will cease to recognize a Domestic Partnership as of the date stated on a valid "Termination of Domestic Partner Relationship" form filed with the Plan Administrator.

Dow means a Participating Employer or collectively, the Participating Employers, as determined by the context of the sentence in which it is used, as such is interpreted by the Plan Administrator or his or her delegee.

Employee means a person who:

a. 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, if such statute exists in the Employee's location, and

b. receives payment for services performed for the Participating Employer directly from the Participating Employer's or the Company's Payroll Department.

The definition of "Employee" does not include an individual who is determined by the Plan Administrator or a Participating Employer to be:

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement between the Participating Employer and another business, such as a leasing organization;

2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;

3. an individual who is classified or treated as an independent contractor; or

4. a self-employed individual, as defined in Code § 401(c)(1)(A), which generally means an individual who has net earnings from self-employment in a trade or business in which the personal services of the individual are a material income-producing factor.

If the Plan Administrator or a Participating Employer determines that an individual is not an "Employee," the individual will not be eligible to participate in the Plan, regardless of whether the determination is subsequently upheld by a court or tax or regulatory authority having jurisdiction

over such matters or whether the individual is subsequently treated or classified as an Employee for certain specified purposes. Any change to an individual's status by reason of such reclassification or subsequent treatment will apply prospectively only (*i.e.*, will apply to coverage after the reclassification).

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Hemiplegia means the complete and irreversible paralysis of upper and lower limbs on one side of the body.

Hospital means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24-hour nursing service by registered nurses (R.N.); and (4) is supervised by one or more Physicians. A Hospital does not include: (a) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (b) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (c) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, Domestic Partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes step-parent), brother or sister (includes step-brother or step-sister), or child (includes legally adopted or stepchild).

Inbound Employee means, effective on and after October 1, 2017, a person who is employed by the Company or one of its subsidiaries or affiliates to perform personal services in an employer-employee relationship that is not subject to taxation under the Federal Insurance Contributions Act or similar federal statute; is on international assignment initiated by his or her employer to the U.S., but is not Localized to the U.S. and is not a U.S. citizen or resident; receives payment for services performed for his or her employer from DCOMCO; and is a citizen of a country on file with the Plan Administrator.

However, if such person's employer ceases to be a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code, then such person will no longer be an Inbound Employee.

Initial Claims Reviewer means, with respect to deciding Claims for Plan Benefits, NUFIC. The Initial Claims Reviewer with respect to deciding Claims for an Eligibility Determination is the person, group of persons or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Initial Claims Reviewer for Claims for an Eligibility Determination is listed in *Appendix C. Named Fiduciaries*.

Insured Person for Occupational Accident Insurance coverage means Employees who are covered by the Plan. For Business Travel Accident Insurance coverage, it means Employees, their Spouses or Domestic Partners, and Dependent Children who are covered by the Plan.

Limb means entire arm or entire leg.

Loss with regard to hand or foot means complete severance through or above the wrist or ankle joint; with regard to thumb and index finger means complete severance through or above metacarpophalangeal joints; with regard to eye means total irrecoverable loss of sight in that eye; with regard to speech means total and irrecoverable loss of the entire ability to speak; with regard to hearing means total and irrecoverable loss of hearing in that ear; and with regard to coma means a profound state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation as determined by a licensed physician.

Married or **Marriage** for a person subject to United States federal income taxation means a civil contract between two individuals who have the legal capacity to marry and that is formalized by a marriage license. Whether a person subject to federal income taxation in the United States is "Married" for purposes of the Plan shall be determined in accordance with IRS Revenue Ruling 2013-17 and other relevant guidance issued by the Internal Revenue Service and the Department of Labor. For a person who is not subject to United States federal income taxation "Married" or "Marriage" means legally married under the laws of the country or jurisdiction either where the marriage is entered into or where the person resides. For periods before September 16, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Plan then in effect.

Medically Necessary Rehabilitative Training Service/Medically Necessary means any medical service, medical supply, medical treatment or Hospital confinement (or part of a Hospital confinement) that: (1) is essential for physical rehabilitative training due to the injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

OAI means the Occupational Accident Insurance component of the Plan.

Occupational means while on the business of Dow or while On Premise of Dow.

On-Premise means while and in consequence of performing any assigned occupational duties for which compensation is received at the Insured Person's regular place of employment with Dow, but does not include during the course of everyday travel to and from work.

Outbound Employee means, effective on and after October 1, 2017, a person who is employed by the Company or one of its subsidiaries or affiliates to perform personal services in an employer-employee relationship that is not subject to taxation under the Federal Insurance Contributions Act or similar federal statute; is not a U.S. citizen or resident alien; was working in the U.S.; is on international assignment initiated by his or her employer outside the U.S. and is expected to return to the U.S. for employment with a Participating Employer; receives payment for services performed for his or her employer from DCOMCO; and is a citizen of a country on file with the Plan Administrator.

However, if such person's employer ceases to be a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code, then such person will no longer be an Outbound Employee.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Participant means each Employee who, in accordance with Article III of the Plan Document, is eligible to participate in the Plan and remains eligible for benefits under the Plan.

Participating Employer means the Company or one of its subsidiaries or affiliates that the Company authorizes to participate in the Plan. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: (1) the Insured Person; (2) an Immediate Family Member; or (3) retained by the Policyholder.

Plan means The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan, together with any and all amendments and supplements hereto.

Plan Administrator means the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Plan Administrator is listed in *Appendix C. Named Fiduciaries*.

Plan Document means the legal instrument under which the Plan is operated. The insurance policy through which Plan benefits are funded and this SPD are part of the Plan Document.

Principal Sum means the amount described in Section 4.3.3. or 5.3.2. , whichever is applicable.

Quadriplegia means complete and irreversible paralysis of both upper and lower limbs.

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

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area due to an injury that is a full-thickness or third-degree burn, as determined by a Physician. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.

Specialized Aviation Activity means an aircraft while it is being used for one or more of the following activities:

- acrobatic or stunt flying
- racing
- any endurance tests
- any flight on a rocket-propelled or rocket-launched aircraft
- fire fighting
- exploration
- pipe line inspection
- power line inspection
- any form of hunting
- bird or fowl herding
- aerial photography
- banner towing
- any test or experimental purpose

- any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Spouse means a person who is Married to the Employee.

Summary Plan Description or **SPD** means the summary plan description for the Plan. The SPD is an integral part of the Plan Document.

Termination of Domestic Partnership occurs when you 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 Plan until the Plan Administrator has received the signed statement.

Total Disability means a person is prevented from performing any and every duty pertaining to his or her occupation.

Total and Permanent Disability means that you are totally and permanently disabled and are prevented from engaging in any occupation or employment for compensation or profit for which you are reasonably qualified through education, training or experience. The disability must occur within one year of the date of the accident.

Uniplegia means the complete and irreversible paralysis of one Limb.

VPHR means the Vice President of the Company with the senior responsibility for human resources.

Appendix B. Claims Procedures

A "Claim" is a written request by a claimant for *Plan Benefits* or an *Eligibility Determination* containing the information described below that is delivered to the applicable Claims Administrator. There are two types of Claims: A "Claim for an Eligibility Determination" and a "Claim for Plan Benefits."

- A *Claim for an Eligibility Determination* is a request for a determination as to whether a claimant is eligible to enroll in the Plan or as to the amount a claimant must contribute towards the cost of coverage.

- A *Claim for Plan Benefits* is a request for plan benefits.

You must follow the claims procedures for either Claims for a Plan Benefit or Claims for an Eligibility Determination, whichever applies to your situation. See the section entitled *Claims for Plan Benefits* for the procedures regarding Claims for Plan Benefits. See the section entitled *Claims for an Eligibility Determination* for the procedures regarding Claims for Eligibility Determinations.

B.1 Deadline to File a Claim and File Proof of Claim

Claims for Plan Benefits

All Claims for Plan Benefits must be filed within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible.

Claims for an Eligibility Determination

A Claim for an Eligibility Determination must be filed before the end of the year in which you seek enrollment or for which you claim you were charged an incorrect premium. Failure to file a Claim within the deadline will result in denial of the Claim.

B.2 Who Will Decide Whether to Approve or Deny My Claim?

The Plan has more than one Claims Administrator. The initial determination is made by the Initial Claims Reviewer. If you appeal an initial determination, the appellate decision is made by the Appeals Administrator. Each of the Claims Administrators is a named fiduciary of the Plan with respect to the respective types of Claims that they process.

Claims for an Eligibility Determination

For Claims for an Eligibility Determination, the Initial Claims Reviewer and the Appeals Administrator are the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons or entity designated as Initial Claims Reviewer and Appeals Administrator are listed in *Appendix C. Named Fiduciaries*.

Claims for Plan Benefits

For Claims for Plan Benefits, the Initial Claims Reviewer and the Appeals Administrator are NUFIC.

B.3 Authority of Claims Administrators and Your Rights under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Plan and to make findings of fact in order to carry out their respective Claims decision-making responsibilities. However, the Claims Administrators' determinations are subject to the interpretation of the Plan Document made by the Plan Administrator.

Interpretations and claims decisions by Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Plan under section 502 of the Employee Retirement Income Security Act (ERISA) in federal court, provided you complete the claims procedures described in this Appendix (or the Claims Administrator fails to timely respond to your Claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see the *Litigation* section for the deadline for filing a lawsuit.

B.4 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Participant. The Plan will recognize a person as a Plan 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 will also be recognized by the Plan.

B.5 Claims for an Eligibility Determination

B.5.1 Information Required In Order To Be A Claim. For Claims that are requests for *Eligibility Determinations*, the Claim must be in writing and contain the following information:

- Name of the Employee, and the name of the person (Employee, Spouse/Domestic Partner, Dependent Child, as applicable) for whom an Eligibility Determination is being requested;
- Name of the plan for which the Eligibility Determination is being requested (The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan); and
- If the eligibility determination is being requested for the Employee's Dependent:
    - a description of the relationship of the dependent to the Employee (*e.g.*, Spouse/Domestic Partner, Dependent child, etc.); and
    - documentation of such relationship (*e.g.*, marriage certificate/statement of Domestic Partnership, birth certificate, etc.)

Claims for an Eligibility Determination must be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, Michigan 48641
Attention: Initial Claims Reviewer for BTA/OAI Plan (Eligibility Determination)

B.5.2 Initial Determination . If you submit a Claim for an Eligibility Determination, the Initial Claims Reviewer for Claims for an Eligibility Determination 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 after the date that you submitted your Claim, except that under special circumstances, the Initial Claims Reviewer for Claims for an Eligibility Determination may have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer for Claims for an Eligibility Determination 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 for Claims for an Eligibility Determination 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 Plan provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer for Claims for an Eligibility Determination needed additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

B.5.3 Appealing the Initial Determination. If the Initial Claims Reviewer for Claims for an Eligibility Determination has denied your Claim, you may appeal the decision. If you appeal the Initial Claims Reviewer for Claims for an Eligibility Determination's decision, you must do so in writing within 60 days of receipt of the Initial Claims Reviewer for Claims for an Eligibility Determination's determination, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator for Claims for an Eligibility Determination. Your written appeal must include the following information:

- The name of the Employee and the name of the person (Employee Spouse/Domestic Partner, Dependent Child, as applicable) for whom an eligibility determination is being requested;

- Name of the plan for which the Eligibility Determination is being requested (The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan); Name of the benefit coverage (BTA or OAI);

- Reference to the Initial Determination; and
- Explanation of the reason why you are appealing the Initial Determination.

Appeals of Eligibility Determination Claims should be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for BTA/OAI Plan (Appeal of Eligibility Determination)

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

After the Appeals Administrator for Claims for an Eligibility Determination receives your written request to appeal the initial determination, the Appeals Administrator for Claims for an Eligibility Determination will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator for Claims for an Eligibility Determination will look at the Claim anew. The Appeals Administrator for Claims for an Eligibility Determination is not the same person as the person who made the initial decision to deny the Claim. In addition, the Appeals Administrator for Claims for an Eligibility Determination is not a subordinate who reports to the person who made the initial decision to deny the Claim.

The Appeals Administrator for Claims for an Eligibility Determination will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days after the written request for appellate review, except that under special circumstances, the Appeals Administrator for Claims for an Eligibility Determination may have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator for Claims for an Eligibility Determination needs such an extension, s/he 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 s/he will make his or her determination. If an extension is needed because the Appeals Administrator for Claims for an Eligibility Determination determines that s/he does not have sufficient information to make a decision on the Claim, s/he will describe any additional material or information necessary to submit to the Appeals Administrator for Claims for an Eligibility Determination, and provide you with the deadline for submitting such information.

The period for deciding your Claim may, in the sole discretion of the Appeals Administrator for Claims for an Eligibility Determination, be tolled until the date

you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator for Claims for an Eligibility Determination may decide the Claim without the additional information.

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

B.6 Claim for Plan Benefits

If you are involved in an accident and suffer a loss that may be covered under the Plan, follow the steps below to file a Claim for Plan Benefits. Any decision to retroactively cancel your coverage under the Plan (for a reason other than the failure to pay premiums) will be treated as a decision by the Initial Claims Reviewer to deny a Claim for Plan Benefits.

NUFIC is the Initial Claims Reviewer for Claims for Plan Benefits and the Appeals Administrator for Claims for Plan Benefits.

B.6.1 Notification of Accident. Within 20 days or as soon thereafter as possible, notify the BTA/OAI Claims Processor, by contacting HR Solutions, of the accident, along with a brief description of the circumstances, the type of injury, the date and location of the accident, and the names of the Employee, Spouse or Domestic Partner, and/or Dependent Child involved. Your supervisor, business partner, family member, or beneficiary may provide this notification on your behalf.

The BTA/OAI Claims Processor will complete as much of the applicable claim form as possible and send it to you or your beneficiary along with instructions regarding required additional information.

One of the following claim forms will be provided to the claimant:

- Accidental Death Claim Form
- Accidental Dismemberment/Paralysis Claim Form
- Permanent Total Disability Claim Form

B.6.2 Proof of Loss. Proof of loss must be furnished to NUFIC within 90 days after the date of the loss. If the loss is for a coma, then proofs of eligibility must be furnished at such intervals as NUFIC may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required by NUFIC.

B.6.3 How to File Accidental Death Claims. In addition to the information requested on the Accidental Death Claim form, the following information and documents will be required before submitting a Claim to the Insurer. Your local HR Solutions contact and BTA/OAI Claims Processor will assist in gathering the Company-related information:

- Annual Base Salary in home-country currency of the Employee on the date of the accident.
- Job Description.
- Brief written description of the accident, including date, time, and location of the incident.
- Certified copy of the death certificate.
- Copy of the police report, internal accident report and, if applicable, autopsy report.
- Copy of newspaper or other articles related to the accident.
- For BTA claims, an itinerary, appointment calendar or other supporting documents confirming the Insured Person was traveling on approved Company business when the accident occurred
- For BTA claims, confirmation of approved business travel.
- If the death was a result of injuries sustained in an automobile accident, written statement from a police officer, fire fighter, paramedic, ambulance personnel, or fellow passenger indicating whether or not a seat belt was worn by the Insured Person at the time the accident occurred. If this information is included in the police report, an additional statement is not necessary.
- Copy of the beneficiary designation.
- If the Beneficiary is a minor child, include a certified copy of the Court appointment naming the guardian of the minor child's estate.
- If there is no beneficiary designation, the full name and address of the Insured Person's Spouse or Domestic Partner.
- If there is no Spouse or Domestic Partner, the full name, address, and birth date of each child. A certified copy of the Court appointment naming the guardian of the minor children's estate is needed as well.
- If there is no Child, the full name and address of the Insured Person's parents.

- If there are no parents, the full name and address of the Insured Person's brothers and sisters.

- If there are no brothers and sisters, a certified copy of the Court appointment naming the Administrator or Executor of the participant's estate.

Send the completed claim to:

BTA/OAI Claims Processor
The Dow Chemical Company
North America Benefits
P. O. Box 2169
Midland, MI 48641-2169
USA

The BTA/OAI Claims Processor will forward your Claim to:

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987
USA
1-800-551-0824

B.6.4 How to File Severe Burn and Accidental Dismemberment/Paralysis Claims. In addition to the information requested on the Accidental Dismemberment/Paralysis Claim form, the following information and documents will be required before submitting a Claim to NUFIC. Your local HR Solutions contact and the BTA/OAI Claims Processor will assist in gathering the Company-related information:

- Annual Base Salary in home-country currency of the Employee on the date of the accident

- Job Description

- Brief written description of the accident, including date, time, and location

- Copy of the police report and, if applicable, internal accident report

- Copy of newspaper or other articles related to the accident

- For BTA claims, an itinerary, appointment calendar or other supporting documents confirming the Insured Person was traveling on Company business when the accident occurred

- For BTA claims, confirmation of approved business travel

Send the completed claim to:

BTA/OAI Claims Processor
The Dow Chemical Company
North America Benefits
P. O. Box 2169

The BTA/OAI Claims Processor will forward your Claim to:

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987

Midland, MI 48641-2169
USA

USA
1-800-551-0824

B.6.5 How to File Permanent Total Disability Benefit Claims. In addition to the information requested on the Permanent Total Disability claim form, the following information and documents will be required before submitting a Claim to NUFIC. Your local HR Solutions contact and BTA/OAI Claims Processor will assist in gathering the Company-related information:

- The Employee's Annual Base Salary in home-country currency on the date of the accident
- Job Description
- Educational background
- Work history, including jobs performed with any prior employers
- For BTA claims, an itinerary, appointment calendar or other supporting documents confirming the Insured Person was traveling on Company business when the accident occurred
- For BTA claims, confirmation of approved business travel.
- Brief written description of the accident, including date, time, and location
- Copy of the police report and internal accident report if applicable
- Copy of newspaper or other articles related to the accident
- Depending on the regulations in your location and the nature of the Permanent Total Disability (e.g., coma), it may be necessary to provide a certified copy of a court order appointing a guardian for the Insured Person.

Send the completed claim to:

BTA/OAI Claims Processor
The Dow Chemical Company
North America Benefits
P. O. Box 2169
Midland, MI 48641-2169
USA

The BTA/OAI Claims Processor will forward your claim to:

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987
USA
1-800-551-0824

B.6.6 Legal Actions. No action at law or in equity may be brought to recover on this Plan prior to the expiration of the Applicable Limitations Period described in Section 3.14.1. of this SPD.

B.7 Initial Decision on a Claim for Plan Benefits

NUFIC is the Initial Claims Reviewer for Claims for Plan Benefits and will review your Claim and notify you of its decision to approve or deny your Claim. Claims for Plan Benefits involving a determination of disability will be decided in accordance with Section 0, and all other Claims for Benefits will be decided in accordance with Section B.7.1.

B.7.1 Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims. The Initial Claims Reviewer for Claims for Plan Benefits 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 after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer for Claims for Plan Benefits may have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer for Claims for Plan Benefits 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 for Claims for Plan Benefits 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 Plan provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer for Claims for Plan Benefits needed additional information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

B.7.2 Permanent Total Disability Benefit Claims for Claims Filed after April 1, 2018. The Initial Claims Reviewer for Claims for Plan Benefits will review your Claim and notify you of its decision to approve or deny your Claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer for Claims for Plan Benefits may have up to two (2) additional extensions of 30 days each (totaling 60 days) to provide you such notification. If the Initial Claims Reviewer for Claims for Plan Benefits needs such extensions, it will notify you prior to the expiration of the initial 45-day period (or the first 30-day extension period if a second 30-day extension period is needed), state the reason why such an extension is needed, and state when it will make its determination.

If an extension is needed because you did not provide sufficient information or filed an incomplete Claim, the period for deciding your Claim may, in the sole discretion of the Initial Claims Reviewer for Claims for Plan Benefits, be tolled from the date on which the notification of extension is sent to you until the date on which you respond to the request for additional information. If you do not provide the additional information within 45 days, the Initial Claims Reviewer for Claims for Plan Benefits will decide the Claim without the additional information.

If the Initial Claims Reviewer for Claims for Plan Benefits denies the Claim, the written notification of the decision will include:

- The specific reason or reasons for the denial of the Claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
- An explanation of the Plan's appeal procedures and the applicable time limits;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your Claim, without regard to whether the advice was relied upon in denying your Claim; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits);
- If the denial of your Claim was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Initial Claims Reviewer for Claims for Plan Benefits under applicable federal regulations; and
- A statement of your right to bring a civil action under section 502(a) of ERISA, if your Claim is denied upon review.

B.8 Appealing a Denial of a Claim for Plan Benefits

NUFIC is the Appeals Administrator for Claims for Plan Benefits and will review your appeal and notify you of its final decision. Claims for Plan Benefits involving a

determination of disability will be decided in accordance with Section B.8.2, and all other Claims for Benefits will be decided in accordance with Section B.8.1.

B.8.1 Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims. If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. If you appeal the Initial Claims Reviewer's decision, you must do so in writing within 60 days of receipt of the Initial Claims Reviewer's determination, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator for Claims for Plan Benefits. Your written appeal must include the following information:

- Employee name;
- Employee number;
- Dependent or beneficiary name if the Dependent or beneficiary is the person who is appealing the Initial Claims Reviewer's decision;
- Name of the plan for which the Eligibility Determination is being requested (The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan);
- Name of the benefit coverage (BTA or OAI);
- Reference to the Initial Determination; and
- An explanation of the reason why you are appealing the Initial Determination.

Send the appeal to:

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987
USA
1-800-551-0824

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

After the Appeals Administrator for Claims for Plan Benefits receives your written request to appeal the initial determination, the Appeals Administrator for Claims for Plan Benefits will review your Claim. Deference will *not* be given to the initial

adverse decision, and the Appeals Administrator for Claims for Plan Benefits will look at the Claim anew.

The Appeals Administrator for Claims for Plan 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 Appeals Administrator may have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator for Claims for Plan 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 state when it will make its determination.

If an extension is needed because the Appeals Administrator for Claims for Plan Benefits determines that it does not have sufficient information to make a decision on the Claim, it will describe any additional material or information necessary to submit to the Appeals Administrator for Claims for Plan Benefits, and provide you with a deadline for submitting such information. The period for deciding your Claim may, in the sole discretion of the Appeals Administrator for Claims for Plan Benefits, be tolled until the date you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator for Claims for Plan Benefits will decide the Claim without the additional information.

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

You also may request NUFIC to provide you with copies of documents, records and other information relevant to your Claim as determined by NUFIC in its sole discretion. The written request must be submitted no later than 120 days after the appeal denial notification. This information will be provided at no cost to you.

B.8.2 Permanent Total Disability Benefit Claims. If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. You must file a written appeal within 180 days of receipt of the notice of denial from the Initial Claims Reviewer for Claims for Plan Benefits, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator for Claims for Plan Benefits, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

- Employee name;
- Employee number;
- Dependent or beneficiary name, if the Dependent or beneficiary is the person who is appealing the Initial Claims Reviewer's decision;

- Name of the plan for which the Eligibility Determination is being requested (The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan);

- Name of the benefit coverage (BTA or OAI);

- Reference to the Initial Determination; and

- An explanation of the reason why you are appealing the Initial Determination.

Send the appeal to:

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987
USA
1-800-551-0824

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

After the Appeals Administrator for Claims for Plan Benefits receives your written request to appeal the initial determination, the Appeals Administrator for Claims for Plan Benefits will review your Claim. In reviewing your appeal:

- Deference will *not* be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The person who will review your appeal will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim.

- The Appeals Administrator for Claims for Plan Benefits will take into account all comments, documents, records, and other information submitted to the Appeals Administrator for Claims for Plan Benefits that is related to the Claim without regard to whether such information was submitted or considered in the initial determination.

- If the initial determination was based on medical judgment, the Appeals Administrator for Claims for Plan Benefits will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person consulted in connection with the initial determination, and will not be a subordinate who reports to the person who was consulted in connection with the initial determination.

- The Appeals Administrator for Claims for Plan Benefits will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial decision, without regard to whether the advice was relied upon in making the initial decision.
- In addition, for Claims for Plan Benefits arising after April 1, 2018, the Appeals Administrator for Claims for Plan Benefits will provide you with the following information, free of charge, as soon as possible and in advance of the deadline for notifying you of the Appeals Administrator for Claims for Plan Benefits' decision:
    - Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit decision in connection with the Claim; and
    - Any new or additional rationale for issuing an adverse benefit decision on appeal.

The Appeals Administrator for Claims for Plan Benefits will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request for appellate review, except that under special circumstances, the Appeals Administrator for Claims for Plan Benefits may have up to an additional 45 days to provide written notification of the final decision. If the Appeals Administrator for Claims for Plan Benefits needs such an extension, it will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the period for deciding your Claim may, in the sole discretion of the Appeals Administrator for Claims for Plan Benefits, be tolled from the date on which the notification of extension is sent to you until the date on which you respond to the request for additional information. If you do not provide the additional information within 45 days, the Appeals Administrator for Claims for Plan Benefits will decide the Claim without the additional information.

For All Appeals Filed after April 1, 2018: If the Appeals Administrator for Claims for Plan Benefits denies the Claim on appeal, the Appeals Administrator for Claims for Plan Benefits will send you a final written decision that includes:

- The specific reason or reasons why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Appeals Administrator for Claims for Plan Benefits under applicable federal regulations;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about the voluntary appeal procedures;

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your appeal, without regard to whether the advice was relied upon in denying your appeal; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits);

- If the denial of your Claim on appeal was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and

- A statement of your right to bring a civil action under section 502(a) of ERISA and any deadline for filing a lawsuit, including the calendar date of the deadline to file a lawsuit for your Claim.

Appendix C. Named Fiduciaries as of October 1, 2019

The Named Fiduciaries are designated by the Plan Sponsor in accordance with the Plan Document. This Appendix C includes the Named Fiduciaries as of October 1, 2019. However, the Named Fiduciaries may be changed from time to time. For inquiries about the persons or entities currently serving as Named Fiduciaries, call +1 (833) 693-6947 (USA) or visit www.dowbenefits.com .

Named Fiduciary	Dow Title	Named Individual	Effective Date
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Kim Gora	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Tammie Hunt	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Associate HR Specialist	Emily Small	October 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Associate HR Specialist	Matthew Salim	October 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	Benefits Plan Manager	Holly Gerisch	January 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	North America Benefits Leader	Ryan Marra	January 1, 2019
Plan Administrator	Global Benefits Director	Bryan Jendretzke	January 1, 2019
Plan Administrator	Benefits Plan Manager	Holly Gerisch	January 1, 2019