Summary Plan Description for:

The Dow Chemical Company
Long Term Disability Program

(Applicable to Those Who Were Fully Disabled Prior to January 1, 2008)

ERISA Plan #506

Effective January 1, 2019 and thereafter until superseded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) or by requesting a copy from the Retiree Service Center (800-344-0661) or by submitting your request through the Dow Benefits website's Message Center (http://dowbenefits.ehr.com).

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

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Overview

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Long Term Disability Program Applicable to Those Who Were Fully Disabled Prior to January 1, 2008 (ERISA Plan #506) (the "Plan").

If you were actively at work on or after January 1, 2008 for more than 80 hours and were not Fully Disabled prior to January 1, 2008, please refer to the summary plan description for The Dow Chemical Company Long Term Disability Program Applicable to Those Actively at Work On or After January 1, 2008, which is ERISA Plan #606.

Prior to June 1, 2008, the Plan provided coverage for both certain participants who were Fully Disabled prior to January 1, 2008 and certain participants who were Fully Disabled on or after January 1, 2008. As of June 1, 2008, the Plan was amended and restated, renamed "The Dow Chemical Company Long Term Disability Program Applicable to Those Who Were Fully Disabled Prior to January 1, 2008," and applies only to those eligible participants who were Fully Disabled before January 1, 2008.

The Plan is closed to those who were not Fully Disabled prior to January 1, 2008. No new enrollments on or after January 1, 2008 will be accepted. If you have questions about which of these plans applies to you, please call HR Solutions or file a Claim for an Eligibility Determination as described in *Appendix A. Claims Procedures*.

The Plan is intended to provide income protection for you and your family in the event of a lengthy disability when all provisions of the Plan are met and approval is received from the insurance carrier. Eligibility to participate in the Plan is not a guarantee of LTD benefit payments under the Plan.

This Plan is a group disability income protection plan. All benefits provided under the Plan are insured through an insurance policy underwritten by Metropolitan Life Insurance Company ("MetLife").

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."

This SPD is a summary of the MetLife Certificate of Insurance and the Plan Document. If there is any inconsistency between this SPD, the Certificate of Insurance, or the Plan Document, the Certificate of Insurance shall govern. If there is an inconsistency between the SPD and the Plan Document, the Plan Document shall govern. The Plan Document is available upon request from the Plan Administrator identified in the *ERISA Information* section of this SPD.

The Plan is provided to Full-Time and Less-Than-Full-Time active Employees who meet the eligibility criteria. It is offered at no cost to the Employee for up to a 50 percent income protection level ("Option 1"). An additional 16.7 percent (totaling 66.7 percent) of income protection ("Option 2") may be purchased by eligible Employees who are Full-Time active Salaried Employees or are Full-Time active Hourly Employees whose collective bargaining unit and the Participating Employer have agreed to Option 2. When LTD benefits are approved, the LTD benefit is designed to be offset by other disability benefits such as, but not limited to, Workers' Compensation and Social Security. LTD benefits provide partial income replacement while you are disabled as a result of injury or illness, as defined by the Plan.

As used in this SPD, references to the "Company" are to The Dow Chemical Company. References to "Participating Employer" mean the Company or any other corporation or business entity 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 Controlled Group. If the entity ceases to be a member of the Controlled Group, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the "Controlled Group." "Controlled Group" is with respect to The Dow Chemical Company, and means a controlled group of corporations or entities within the meaning of

section 414(b) or section 414(c) of the Code. "Dow" means a Participating Employer, or collectively, the Participating Employers, as determined by the context of the sentence. Words that are capitalized are either defined in this SPD, the Plan Document, or the Certificate of Insurance.

Eligibility

Under the Plan, you are "eligible" for coverage if you meet certain requirements. "Eligibility" is different from "effective date of personal benefits". In order to be "covered" under the Plan, you must be both "eligible" and have met the requirements described in the "Effective Date of Personal Benefits" section of this SPD.

Who is eligible for coverage?

Regular Salaried Employees of a Participating Employer with Full-Time status who were actively at work or on an approved Family Leave ***prior to January 1, 2008, and who became Fully Disabled prior to January 1, 2008*** are eligible to participate in Options 1 and 2 of the Plan as described below. In addition, except as otherwise provided in the applicable collective bargaining agreement, regular, Full-Time Bargained-for Employees who otherwise meet the requirements above and whose collective bargaining units and the Participating Employer have agreed to the Plan are eligible to participate in Options 1 and 2 of the Plan as described below. If the terms of the collective bargaining agreement specifically address which Employees are eligible or not eligible for this Plan, then the terms of such collective bargaining agreement shall govern.

Employees with Less-Than-Full-Time status who were actively at work ***prior to January 1, 2008 and who became Fully Disabled prior to January 1, 2008*** are eligible for Option 1 of the Plan as described below. (Note that if you are a Full-Time Employee who was enrolled in Option 2 prior to January 1, 2008, and then became Less-Than-Full-Time mid-year (prior to January 1, 2008), you were no longer eligible for Option 2 coverage at the time you changed to Less-Than-Full-Time status.)

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

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

Who is not eligible for coverage?

You are no longer eligible for LTD coverage if you become Fully Disabled on or after January 1, 2008, or on or after the date you:

- Transfer from the U.S. payroll and have earnings exempt from the U.S. Social Security tax.
- Change to part-time status (Note: part-time status is different than Less-Than-Full-Time status).
- Take a Leave of Absence, other than a Family Leave, Military Leave, or other leave described in the Plan Document.
- Terminate your employment with Dow and/or a Participating Employer.
- Receive pension benefits under a pension plan sponsored by a Participating Employer.[1]

[1] This provision does not apply to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

You are not eligible for coverage under the Plan if you are, or were, a Union Carbide Employee who became Fully Disabled on or after January 1, 2008, or:

- who was totally disabled on or after June, 2001 while covered under the Union Carbide Corporation Long Term Disability Plan (UCC LTD Plan), and
- whose 6-month Elimination Period under the UCC LTD Plan had begun (and might have been extended by UCC's salary continuation policy), and
- during the 6-month Elimination Period, (which might have been extended by UCC's salary continuation policy), you recovered sufficiently from your disability to return to work, but
- the same illness or injury prevented you from working for 90 or more full or partial days during the 6-month Elimination Period.

If you are, or were, a UCC employee described in the bulleted paragraph above, the days you returned to work are not recognized by the Dow LTD Plan as days you were actively at work at a Participating Employer. However, if you did not meet the description in the bulleted paragraph and you worked for **90 or more** full or partial days during the UCC LTD Plan's 6-month Elimination Period, the Dow LTD Plan recognized the days you returned to work as days you were actively at work at a Participating Employer, and then you would have been eligible to participate in the Dow LTD Plan.

If you have been approved for benefit payments under the Dow LTD Program Applicable to Those Actively at Work On or After January 1, 2008 (ERISA Plan #606), UCC LTD Plan, Dow AgroSciences Long Term Disability Insurance Plan, Mycogen Long Term Disability Plan underwritten by United of Omaha Life Insurance Company, or any other long-term disability plan sponsored by a subsidiary or affiliate of Dow, then you are not eligible for coverage under the Plan.

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan, or have been told that you are not, see *Appendix A. Claims Procedures*.

Effective Date of Personal Benefits

Option 1 (50% income replacement)

If you met the eligibility requirements, then your effective date of personal benefits for Option 1 benefits was the date that you met the "Active at Work Requirement" for Option 1 benefits. This is when your coverage became effective.

Option 2 (66.7% income replacement)

If you met the eligibility requirements and enrolled for Option 2 benefits, then your effective date of personal benefits for Option 2 benefits was the date that you met the "Active at Work Requirement" applicable to Option 2 benefits. This is when your coverage became effective.

Active at Work Requirement

For Option 1 benefits, the "Active at Work Requirement" requires that on any date that your personal benefits under Option 1 are to become effective, you must be actively at work with the Participating Employer for at least one day of your regularly scheduled work hours in order for those benefits to take effect.

For Option 2 benefits, the "Active at Work Requirement" requires that on any date that your personal benefits under Option 2 are to become effective, you must be actively at work as an Employee on that date and have been actively at work as an Employee for at least one day of your regularly scheduled work hours for the 30 days immediately preceding that date in order for those benefits to take effect.

Eligible Employees with Less Than One Year of Continuous Service have Limited Protection

If you qualified for LTD payments, your LTD payment period was limited if you had less than one year of continuous service. In determining whether you had one year of continuous service, the "Elimination Period" as defined under the *Six Month Elimination Period* section of this SPD, did not count toward the one-year requirement.

Eligible Employees who did **not** complete one year of continuous full-time (or Less-Than-Full-Time, if applicable) service who met the "Active at Work Requirement" for Option 1 were automatically covered under Option 1 of the Plan; provided that they were on the U.S. payroll with Social Security tax withheld. New hires who were eligible Full-Time Employees were permitted to enroll in Option 2 within 90 days of their hire date. Otherwise, eligible Full-Time Employees were permitted to enroll in Option 2 during open enrollment or within 90 days of a Change in Status. (See *Change in Status* section of this SPD.) Coverage was effective immediately upon the Plan's receipt of the enrollment information and the Employee's satisfaction of the Active at Work Requirement.

If you had less than one year of continuous service and you became disabled and were approved to receive LTD payments, the payments were limited such that they would not be paid for longer than 1 year after they began, and they may have ended sooner if other provisions of the Plan described in this SPD apply.

If you were a rehire who was an Eligible Employee, you did not work for at least 12 continuous months prior to your rehire, and you became disabled and were approved to receive LTD payments, the payments were limited. The Plan treated you as if you were a new hire who must complete the one-year continuous service requirement.

If you end your employment with a Participating Employer or are not on a qualified leave of absence under which you may continue coverage under LTD, your coverage ended or ends on the day you leave.

Eligible Employees With One Year or More of Continuous Service

Eligible Employees with one or more years of continuous service while actively at work with a Participating Employer were automatically covered under Option 1 of the Plan. In determining whether you had one year of continuous service, the "Elimination Period" as defined under the *Six Month Elimination Period* section of this SPD, did not count toward the one year requirement. You must have been be on the U.S. payroll, with Social Security tax being withheld. During open enrollment or within 90 days of a Change in Status, you were permitted to elect to enroll in Option 2. Option 2 coverage was not effective until you met the "Active at Work Requirement." If you end your employment with a Participating Employer or are not on a leave of absence under which you may continue coverage under the Plan, your coverage ended or ends on the day you leave. If you were a rehire who is an Eligible Employee who has met the one year continuous service active at work requirement prior to your rehire, the Plan recognized your prior service.

Enrollment

Enrollment is closed. Only those who were already enrolled prior to January 1, 2008, and were Fully Disabled prior to January 1, 2008 may participate in the Plan. If you were actively at work on January 1, 2008, were Fully Disabled prior to that date, and you worked more than 80 hours on or after January 1, 2008, you are not eligible to enroll in this Plan.

Option 1 (50% income replacement)

For Eligible Employees who became Fully Disabled prior to January 1, 2008, enrollment was automatic for Option 1 benefits; however, coverage was not effective until you met the "Active at Work Requirement".

Option 2 (66.7% income replacement)

New hires hired prior to January 1, 2008 who were eligible Full-Time Employees were permitted to enroll in the additional 16.7 percent coverage offered under Option 2 benefits within 90 days of their hire date. In addition, eligible Full-Time Employees prior to January 1, 2008 had the opportunity to enroll for the additional 16.7 percent optional coverage during open enrollment. After the enrollment period ended, the Participant was not permitted to change or make new selections until the next enrollment period, unless the Participant had a change in status. After you had enrolled in Option 2, coverage was not effective until you had met the Active at Work Requirement.

Contributions

Dow provided Option 1 coverage at no cost to you. Eligible Employees who enrolled in Option 2 were required to pay a premium. The premiums that eligible Employees were required to pay for Option 2 were described in the annual Choices enrollment materials.

Participants are not required to pay a premium after December 31, 2007, even though coverage for those who were Fully Disabled as of January 1, 2008 continues.

If the last payroll period for Participants for a Plan Year occurred partly during a current Plan Year and partly during the next Plan Year, the Plan Administrator had the full and complete discretion to modify the Participant contributions for Option 2 in any way that the Plan Administrator deemed administratively efficient, including modifying the Participant contributions for the last payroll period without the Participant's consent.

If you were on a leave of absence approved by the Participating Employer that provided eligibility for Option 2 under this Plan, the Plan Administrator had the full discretion to make special administrative arrangements as necessary, such as deferring Employee contributions on a temporary basis during the leave of absence, and requiring the Employee to repay premiums for the coverage when the Employee returns to work, or any other arrangements the Plan Administrator deemed appropriate.

For more information about how the Plan is funded, see the *Funding* section of this SPD.

Reduction of Certain Elections to Prevent Discrimination

The Plan Administrator has the unilateral authority to reduce the benefit election of certain Participants if such a reduction is necessary to prevent the Plan from becoming discriminatory within the meaning of Code Section 125(b). If the Plan Administrator determines or is informed by the Administrator of The Dow Chemical Company Flexible Spending Plan ("Cafeteria Plan") before or during any Plan Year that the Cafeteria Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees or Highly Compensated Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees or Key Employees with or without the consent of such employees.

Receiving Plan Benefits

Six Month Elimination Period

In order to have received benefits under the Plan, you must have been Fully or Totally Disabled continuously for at least six months and met the Full or Total Disability definition. The six-month period is called the "Elimination Period." "Elimination Period" means, with respect to a period of disability, the later of:

- the first 6 months that you were Fully Disabled and/or Totally Disabled, or
- the date you were no longer receiving payroll income from the Company's payroll department for salary continuation under a Dow personal illness or medical leave policy.

During the Elimination Period, you were permitted to attempt to return to your job at the Participating Employer on a trial basis without interrupting the six-month "continuously disabled" period if:

- The number of hours of active work during the Elimination Period was 80 or fewer hours, and
- The same disability prevented you from working more than 80 hours during the Elimination Period.

If you attempted to return to your job at the Participating Employer and worked for more than 80 hours, the Elimination Period was interrupted, and you must have begun a new Elimination Period. The new Elimination Period would begin with the first absence following the last day actively worked. Additionally, no portion of the previous Elimination Period would be counted toward the new Elimination Period.

For purposes of determining whether the 80 hours is met, hours recorded by the employer as vacation, unexcused absence, personal illness, medical leave or family leave time did not count toward hours of active work.

Primary Benefit Period (Phase 1)

The Primary Benefit Period (sometimes also called Phase 1 or First Phase) started on the day after the Elimination Period ended, if MetLife approved your Claim for Plan Benefits. It is a period during which benefits are paid. In order for MetLife to have approved your Claim for Plan Benefits, you must have met the requirements described in the *Effective Date of Personal Benefits* section above, and you must have met the definition of Fully Disabled. The Primary Benefit Period is defined as follows:

> With respect to a Period of Disability, the period of time, if any, which starts on the day after the end of the Elimination Period and which ceases on the earliest of:
>
> 1. the day 24 months after that Elimination Period ends; and
> 2. the day that Period of Disability ends; and
> 3. your Terminal Date.

A Period of Disability is defined as:

> Any one continuous period of time during which you are Fully Disabled and/or Totally Disabled because of one or more causes. If you return to active work with the Participating Employer after a Period of Disability for which monthly benefits have been paid under the Plan, successive Periods of Disability, due to the same or related cause or causes, which:
>
> - start while you are covered for Long Term Disability Benefits; and
> - are separated by less than 6 continuous months of active work with the Participating Employer on a full-time basis;
>
> will be considered as one continuous Period of Disability.

Definition of Fully Disabled or Full Disability

You cannot, because of a sickness or an injury, perform your regular job or any other reasonably appropriate job your Participating Employer can provide.

Monthly Benefits will not be paid with respect to Full Disability if you fail to provide MetLife proof, when MetLife asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Full Disability. For further information please see the Certificate of Insurance.

With respect to airplane pilots in the Participating Employer's Aviation Department, "Fully Disabled" or "Full Disability" also means you 1) fail, because of your health, to pass the Class II F.A.A. health examination, and 2) the Participating Employer certifies that you have not been redeployed to another job with a Participating Employer.

Secondary Benefit Period (Phase 2)

The Secondary Benefit Period (sometimes also called Phase 2 or Second Phase) started on the day after the Primary Benefit Period ended, if MetLife has approved you for payment of benefits. It is a period during which benefits are paid. In order to be eligible for benefit payments during the Secondary Benefit Period, you must have been receiving benefit payments during the Primary Benefit Period, and you must meet the definition of Total Disability. The Secondary Benefit Period is defined as follows:

> With respect to a Period of Disability, the period of time, if any which starts on the day after the end of a Primary Benefit Period and ceases on the earlier of:
>
> - your Terminal Date; and
> - the day that Period of Disability ends.

Definition of Totally Disabled or Total Disability

You cannot, because of a sickness or an injury:

- do your job; and
- do any other job for which you are reasonably fit by your education, your training or your experience (including work with a Participating Employer, self-employment or work with another employer).

Monthly Benefits will not be paid with respect to Total Disability if you fail to provide MetLife proof, when MetLife asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Total Disability. For further information please see the Certificate of Insurance.

Airplane pilots should note that failure to pass the Class II F.A.A. health examination and certification by the Participating Employer will not by itself satisfy proof of Total Disability for the Secondary Benefit Period (Phase 2). You must also meet the criteria listed in the definition above.

Timetable

Below is a table of key times beginning with Day 1. Day 1 is the date of the disabling event that starts the Elimination Period prior to the Primary Benefit Period. The chart is for illustrative purposes only, and makes the assumption that the Participant files his or her claim for benefits and proofs of Disability on the first day of the fourth month after Day 1, and that the Claim is approved by MetLife for payment effective as of the first day after the end of the 6-month Elimination Period.

Day 1:	Disabling Event resulting in a Full Disability. This is the beginning of the six (6) month Elimination Period. You must be Fully Disabled continuously during the Elimination Period (except as otherwise described in this SPD).
3 Months after Day 1:	You should begin the LTD application process. Call HR Solutions, fill out forms, obtain medical records, and file a Claim for Plan Benefits with MetLife.
6 Months after Day 1:	End of the six (6) month Elimination Period.
6 Months and 1 Day after Day 1:	Beginning of the Primary Benefit Period. You must be Fully Disabled during the Primary Benefit Period.
30 Months after Day 1:	End of Primary Benefit Period.
30 Months plus 1 day after Day 1:	Beginning of the Secondary Benefit Period. You must be Totally Disabled during the Secondary Benefit Period.

Deadline to File a Claim

The deadline to file a Claim for Plan Benefits with MetLife was nine (9) months after Day 1.

The deadline to file proof of a Full Disability with MetLife was 18 months after Day 1. (MetLife may require proof of Full Disability or Total Disability at any time it may reasonably choose.)

Example 1: Matt has an injury that results in him becoming Fully Disabled beginning on January 1. January 1 is Day 1. Matt had 9 months from January 1 to file a claim with MetLife.

Example 2: Ginger has an injury that results in her becoming Fully Disabled beginning on January 1. January 1 is Day 1. Ginger returns to work on a trial basis on February 1. Ginger works for more than 80 hours, thus interrupting the Elimination Period. On March 1, Ginger cannot return back to work due to a

Full Disability. Ginger's new Day 1 was March 1, and she had 9 months from March 1 to file her claim with MetLife.

Note that if there are extenuating circumstances that justify it, MetLife may extend the 9-month deadline. The decision on what constitutes an extenuating circumstance is at the complete discretion of MetLife.

See *Appendix A. Claims Procedures* for how to file a Claim.

Plan Exclusions

Benefits are not payable for disabilities resulting from:

- Attempted suicide or any intentionally self-inflicted illness or injury.
- War, or a warlike action in time of peace or any participation in insurrection, rebellion or riot.
- Alcoholism, narcotic or other drug addiction.
- Committing or attempting to commit a felony, assault or other serious crime.

In addition, benefits will not be paid if you:

- Fail to follow your physician's prescribed treatment.
- Are employed (other than the first six months of "rehabilitative employment" as defined and approved by MetLife).
- Fail to furnish proof of continued disability.
- Fail to reimburse the Plan for overpayments made to you by the Plan while you were waiting for Social Security approval.
- Are receiving pension benefits from a pension plan sponsored by a Participating Employer.[2]

Amount of Coverage

If MetLife approves a Claim for Plan Benefits, payment under Option 1 and Option 2 will provide an amount, when *combined with other disability-related benefits and income*, equal to the amount described below:

Option 1

50% of your Monthly Base Salary if you are a Full-Time or Less Than Full-Time Salaried Employee

Or

50% of your Monthly Base Earnings if you are a Full-Time Hourly Employee

[2] This provision does not apply to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

Option 2

66.7% of your Monthly Base Salary if you are a Full-Time Salaried Employees

Or

66.7% of your Monthly Base Earnings if you are a Full-Time Hourly Employee

For Full Time Salaried Employees, "Monthly Base Salary" means the amount of your base monthly salary as of your last active day at work, as determined by your employer. For Less-Than-Full-Time Employees, "Monthly Base Salary" means your unreduced annual salary as of your last active day at work, as determined by your employer, divided by twelve. For Hourly Employees, "Monthly Base Earnings" means your base annual hourly rate, divided by 12 months. "Base annual hourly rate" means your base annual hourly rate of pay as of your last active day at work, as determined by your employer.

If you were a Union Carbide employee, the Monthly Base Salary or the Monthly Base Earnings is determined using your annual pay at Union Carbide as of December 31, 2001, as determined under the provisions of the Union Carbide Basic Life Insurance Plan until your annual base salary calculated under the normal provisions of the Plan exceed such amount. At that time, the Plan no longer retains the December 31, 2001, Union Carbide annual pay information and looks solely to the annual base salary calculated under the normal provisions of the Plan to determine the amount of your coverage.

Disability related benefits and income include:

- Social Security. You must apply for and actively pursue a Social Security disability benefit, through the administrative law judge level of appeal.
- Workers' compensation, or similar provisions including the Jones Act and the Longshoremen and Harbor Workers' Act, and any amounts resulting from a lawsuit for a Participating Employer work-related injury.
- Employer-sponsored disability income programs for salary continuance.
- No-fault motor vehicle or similar insurance programs.
- Rehabilitative employment earnings.
- Dependent Social Security exceeding 25 percent of your Monthly Base Salary (for Salaried Employees) for the 50 percent benefit, or exceeding 10 percent of your Monthly Base Salary (for Salaried Employees) for the 66.7 percent benefit. Dependent Social Security exceeding 25 percent of your Monthly Base Earnings (for Hourly Employees) for the 50 percent benefit, or exceeding 10 percent of your Monthly Base Earnings (for Hourly Employees) for the 66.7 percent benefit. Your dependents may qualify for Social Security benefits because of your disability. If so, your total combined income from Social Security and LTD may exceed the 50% or 66.7% benefit limitation, whichever is applicable.
- Pension payments from a Participating Employer's Pension Plan.[3]

Note: Before the Plan is obligated to pay you any LTD payments, you MUST show proof to MetLife that you have applied for Social Security. Failure to do so will result in MetLife estimating your Social Security benefits payable and reducing your LTD benefits by that amount. In addition, in order to receive LTD payments, you are required to actively pursue a Social Security disability

[3] This provision does not apply to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

benefit. If a Social Security benefit is denied by the government, you must pursue your remedies under Social Security through the administrative law judge level of appeal at your own cost.

Rehabilitative Employment

Under this Plan, rehabilitative employment is any employment for profit while you are disabled and entitled to receive LTD benefits.

Before starting rehabilitative employment you must obtain approval from MetLife, the Claims Administrator for the LTD Plan. Your LTD benefits will be reduced by 50 percent of your rehabilitative employment income. (Check with MetLife for specifics on rehabilitative employment and the effects on your benefit).

LTD and Retirement Benefits

Generally, you were not eligible for benefits under the Plan if you began receiving pension benefits under a pension plan sponsored by a Participating Employer. [4]

If you are receiving benefits under the Plan and later begin receiving benefits under a Participating Employer's pension plan your benefits under the Plan will stop when your pension payments begin.

The pension plans sponsored by Participating Employers include the Dow Employees' Pension Plan and the Union Carbide Employees' Pension Plan, and any other pension plan sponsored by a Participating Employer.

LTD and Other Benefits

A person who is qualified to receive LTD benefit payments is referred to as a person with "LTD status". When you have LTD status, you are no longer an active Employee of a Participating Employer. While on LTD status, you may be eligible to continue coverage under certain employee benefit plans. The following information is provided in this LTD summary plan description only for your convenience. If there is any inconsistency between this information and the information in the summary plan description for the applicable plan, the summary plan description for the applicable plan shall prevail.

<u>If you have LTD status, coverage **ends** under the following plans on your last day on the payroll:</u>

- **Business Travel Accident (BTA) Insurance.**
- **Dependent Life Insurance.** You or your dependents may convert this coverage within 31 days of the date your LTD status became effective and may select any non-term individual or dependent life insurance policy offered by MetLife with no proof of insurability required. You are responsible for the cost of such coverage. For more information regarding conversion options, call MetLife at 877-275-6387 (877-ASK-MET7).
- **Voluntary Group Accident (VGA) Plan.**

<u>Participation under the following plans is provided for part of the time you have LTD status:</u>

- **Company-Paid Life Insurance**

[4] No part of this section *LTD and Retirement Benefits* applies to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

If the date of your Full Disability is on or after January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:

If you had less than ten (10) years of service under DEPP or UCEPP, you were eligible for up to either 12 months or 24 months of company-paid life insurance coverage. Coverage ended prior to the expiration of the 12-month or 24-month period if you no longer qualified for LTD status. The 12-month period applied if you had less than one (1) year of service under DEPP or UCEPP. The 24-month period applied if you had more than one (1) year of service, but less than ten (10) years of service under DEPP or UCEPP. Currently, if you had ten (10) or more years of service you are eligible for company-paid life insurance coverage until you are no longer eligible to receive payments from LTD.

The amount of coverage is the same as the amount of coverage you had under the applicable company paid life insurance plan on your last day Actively at Work. Currently, the Company pays the cost of this coverage.

If the date of your Full Disability is prior to January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:

You are eligible for the same amount of coverage you had under the applicable company-paid life insurance plan on your last day on the payroll. Currently, the Company pays the cost of this coverage, and coverage continues until you are no longer eligible to receive payments from LTD.

- **Dental Coverage**

  If the date of your Full Disability is on or after January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:

  If you had less than ten (10) years of service under DEPP or UCEPP, you were eligible for up to either 12 months or 24 months of dental coverage beginning on the effective date of your approval for LTD status. Coverage ended prior to the expiration of the 12-month or 24-month period if you no longer qualified for LTD status. The 12-month period applied if you had less than one (1) year of service. The 24-month period applied if you had more than one (1) year of service, but less than ten (10) years of service. If you had ten (10) or more years of service, you are eligible for coverage until you are no longer eligible to receive payments from LTD.

  You will be required to pay the same premiums active employees pay.

  If the date of your Full Disability is prior to January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:

  You were eligible for dental coverage beginning on the effective date of your approval for LTD status. Currently, eligibility for coverage ends when you are no longer eligible to receive payments from LTD and Dow pays the full cost to insure. Once the period of dental coverage ends, you may be able to continue coverage under COBRA by paying the applicable premiums. Check the dental plan's COBRA rules for details.

- **Dependent Care Reimbursement Account (DCRA)**

  If you were enrolled in DCRA, eligible expenses you incurred through the end of the calendar year your LTD status became effective were permitted to be submitted for reimbursement up to the amount you contributed to the account. You must have submitted your claims by April 30 of the following year. After that date, any remaining account balance was forfeited. While on LTD status, you may not make deposits into your Reimbursement Accounts.

- **Dow Employees' Pension Plan (DEPP)**

  If you had ten or more years of credited service under DEPP, you continue to earn credited service toward DEPP retirement benefits while receiving LTD benefit payments. You earn one-half month of credited service under DEPP for each month of disability payment provided by the LTD Plan as specified under DEPP until the date specified under DEPP.

- **Employee-Paid Life Insurance**

  <u>If the date of your Full Disability was on or after January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:</u>

  If you had less than ten (10) years of service under DEPP or UCEPP, you were eligible for up to either 12 months or 24 months of employee-paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applied if you had less than one (1) year of service under DEPP or UCEPP. The 24-month period applied if you had more than one (1) year of service, but less than ten (10) years of service under DEPP or UCEPP. If you had ten (10) or more years of service under DEPP or UCEPP, you are eligible for coverage until you are no longer eligible to receive payments from LTD.

  The amount of coverage depends on the amount of coverage you had on your last day Actively at Work. If you had ½X, then the coverage amount is ½X. If you had 1X or more, then the amount is limited to 1X. You are required to pay the same premiums active employees pay.

  <u>If the date of your Full Disability is prior to January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:</u>

  You are eligible for coverage. Currently, eligibility for coverage ends when you are no longer eligible to receive payments from LTD. The amount of coverage depends on the amount of coverage you had on your last day on the payroll. If you had ½X, then the coverage amount is ½ X. If you had 1X or more, then the amount is limited to 1X. Currently, Dow pays the full cost to insure.

- **Employees' Savings Plan (ESP)** allows you to take distribution of your Employees' Savings Plan account or defer receipt. If you defer, any investment earnings will continue to be reinvested in your account. While you are on LTD status you may not contribute to your Employees' Savings Plan account balance.

- **Health Care Reimbursement Account (HCRA)** reimbursed you for eligible medical expenses that you incurred prior to the effective date of your LTD status, if you elected to participate in HCRA and up to the level of your participation. You must have submitted your claims by April 30 of the following year. After that date, any remaining account balance was forfeited. While on LTD status, you may not make deposits into your Reimbursement Accounts.

- **Long Term Care (LTC)** coverage can be continued with direct billing through John Hancock. Contact John Hancock at 1-800-582-4369.

- **Union Carbide Employees' Pension Plan (UCEPP)**. If you have ten or more years of credited service under UCEPP, you will continue to earn credited service toward UCEPP retirement benefits while receiving LTD benefits. You will earn one-half month of credited service under UCEPP for each month of disability payment provided by the LTD Plan, as specified under UCEPP until the date specified under UCEPP.

- **Retirement Health Care Assistance Plan (RHCAP)**

  If the date of your Full Disability was on or after January 1, 2006 the following applied to you when you began to receive LTD benefit payments:

  Less than Ten (10) Years of Service. If you were a participant of RHCAP and had less than one (1) year of Service under The Dow Chemical Company Retiree Medical Care Program (or Union Carbide Corporation Retiree Medical Care Program if you were employed by a Participating Employer of that program), your RHCAP account balance was paid to you in a lump sum up to a maximum of two (2) times your last annual base salary. There is no Company match. Any excess was forfeited.

  Ten (10) or More Years of Service. If you were a participant of RHCAP and you had 10 or more years of Service under The Dow Chemical Company Retiree Medical Care Program (or Union Carbide Corporation Retiree Medical Care Program if you were employed by a Participating Employer of that program), your RHCAP account balance was suspended. Your RHCAP account continues to be invested, but you are not able to make contributions or utilize the funds in your account while your account is suspended. If you lose LTD status for a reason other than becoming a "retiree" under DEPP or UCEPP, either as a regular retiree, early retiree or disability retiree, your RHCAP account balance will be paid to you in a lump sum up to a maximum of two (2) times your last annual base salary. There will be no Company match. Any excess will be forfeited. If you lose LTD status because you become a "retiree" under DEPP or UCEPP either as an early retiree, regular retiree, or disability retiree, you may use your RHCAP account to pay eligible claims, and will receive the Company match.

  If the date of your Full Disability was prior to January 1, 2006, the following applies to you:

  On your last day on the payroll, your RHCAP account was suspended. Your RHCAP account will continue to be invested, but you will not be able to make contributions or utilize the funds in your account while your account is suspended. If, when you are no longer eligible for payments under LTD, you are a "retiree" under DEPP or UCEPP, you may use your account to pay eligible premiums under the terms of RHCAP. If you lose LTD status for a reason other than becoming a "retiree" under DEPP or UCEPP, either as a regular retiree, early retiree or disability retiree, your RHCAP account balance will be paid to you in a lump sum up to a maximum of two (2) times your last annual base salary. There will be no Company match. Any excess will be forfeited. If you lose LTD status because you become a "retiree" under DEPP or UCEPP either as an early retiree, regular retiree, or disability retiree, you may use your RHCAP account to pay eligible claims, and will receive the Company match.

- **Medical Coverage**

  If the date of your Full Disability was on or after January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:

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

  "Service" means "service" as defined under The Dow Chemical Company Retiree Medical Care Program if your employer is a Participating Employer of The Dow Chemical Company Retiree Medical Care Program. "Service" means "service" as defined under the Union Carbide

Corporation Retiree Medical Care Program if your employer is a Participating Employer of the Union Carbide Corporation Retiree Medical Care Program.

Medical coverage will be provided under The Dow Chemical Company Retiree Medical Care Program if your employer is a Participating Employer of The Dow Chemical Company Retiree Medical Care Program. Medical coverage will be provided under the Union Carbide Corporation Retiree Medical Care Program if your employer is a Participating Employer of the Union Carbide Corporation Retiree Medical Care Program.

You will be required to pay the same premiums active employees pay. If you have less than ten (10) years of "service", once the initial period of medical coverage ends, you may be able to continue coverage under COBRA. Check the medical plan's COBRA rules for details. If you die while you are still eligible for the 12 or 24-month period of medical coverage, your surviving Spouse of Record/Domestic Partner of Record may continue coverage for the remainder of the 12 or 24-month period. After the expiration of the remainder of the 12 or 24-month period, the surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules. If you have ten (10) or more years of Service and you die when you are still eligible for medical coverage, your surviving Spouse of Record/Domestic Partner of Record should check the survivor rules in the medical plan.

<u>If the date of your Full Disability was prior to January 1, 2006, your eligibility began when your LTD benefit payments began. The following applies to you:</u>

Currently, you are eligible for medical coverage until you are no longer eligible to receive payments from LTD, and Dow pays the full cost to insure.

When LTD Benefits End

If you have been approved for LTD benefit payments and are receiving LTD benefit payments, your LTD benefit payments will end (or ended) (Terminal Date) when any *one* of the following applies to your situation:

- You reach age 65, if your Full Disability or Total Disability began before age 60.
- After 60 consecutive months of benefit payments, or when you reach age 70, whichever is earlier, if your Full Disability or Total Disability began between ages 60 and 69.
- After 12 consecutive months of benefit payments, if your Full Disability or Total Disability began between ages 70 and 74.
- After 6 consecutive months of benefit payments, if your Full Disability or Total Disability began on or after age 75.
- If you begin receiving pension benefits under a Participating Employer's pension plan.[5]
- After 12 consecutive months of benefit payments, if you had not completed one year of continuous service.

[5] If your Full Disability or Total Disability began before February 7, 2003, this provision does not apply to you if you began receiving pension benefits under UCEPP before that date.

- If you no longer meet the definition of Full Disability for the Primary Benefit Period, or you no longer meet the definition of Total Disability for the Secondary Benefit Period.
- You receive disability payments from the Union Carbide Long Term Disability Plan after the date that Elimination Period ends.

The date your LTD benefits end is your Terminal Date.

Proof of Claim

Monthly Benefits will not be paid with respect to Full Disability or Total Disability if you fail to provide proof that is satisfactory to MetLife when you file an LTD claim, or later when MetLife asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Full/Total Disability. For further information please see the Certificate of Insurance.

A statement from a physician without objective evidence may not be sufficient proof of Full Disability or Total Disability. It is strongly recommended that you work with your doctor to make sure that MetLife is presented with all available evidence (*e.g.*, medical examinations, tests) to support your claim to MetLife that you meet, or continue to meet, the definition of Full/Total Disability. For example, a current medical examination and tests should be obtained near in time to the date you file your claim for Full Disability to show the current status of your disability. Medical examinations and tests by your treating physician are not paid for by the LTD Plan. If MetLife informs you that you do not have sufficient proof of disability, you should discuss the situation with your physician as soon as possible, to make sure that MetLife is provided all the information that it needs to make a decision on your claim.

A decision by your employer that you cannot perform the essential functions of your job with or without reasonable accommodation is independent of MetLife's decision as to whether you meet the Full Disability definition, and is based on different criteria and requirements of proof than the Full Disability determination by MetLife.

Medical Examinations

Although you are required (at your own expense) to provide proof satisfactory to MetLife of a Full Disability or Total Disability, the Plan reserves the right at any time (while a Claim for Plan Benefits is pending or if you have been approved for payment of benefits), to have you examined by a Doctor of its choice at its own expense when and as often as it reasonably chooses.

Information Exchanged Between the Plan and Your Employer

The Plan may provide your Participating Employer and/or the Company information concerning your claims status, including the date that your benefit payments under the Plan begin or began, or end(ed), and the amount of your benefit.

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 (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 may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant 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 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.

Fraud Against the Plan

If you intentionally misrepresent information to the Plan, knowingly withhold relevant information from the Plan, or deceive or mislead the Plan, the Plan Administrator may (1) terminate your participation in the Plan, retroactively from the date deemed appropriate by the Plan Administrator, or prospectively; (2) require you to reimburse the Plan for amounts it paid, 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, the Plan and/or Dow may pursue civil and/or criminal action against you, or take other legal action. The employer may terminate your employment. If you are terminated from eligibility under any benefit plan sponsored by the Company or an 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.

Tax Treatment of Coverage and Benefits

Your LTD payments are taxable. MetLife does not withhold taxes from your benefit on a mandatory basis. However, you may request withholding by completing a Form W-4S. MetLife will mail you a Form W-2 each year that will report the amount of your taxable LTD benefit and the amount of taxes withheld, if any.

Since tax laws change, you should consult a professional tax advisor for further information. Neither the Company, nor any other Participating Employer or any other affiliate, makes any assertion or warranty about 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.

Funding

All benefits are funded entirely by an insurance policy with MetLife.

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, collective bargaining agreements (if applicable), the Plan Documents 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, collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

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 Plan Participants and beneficiaries.

No one, including your employer 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.

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.

Enforce Your Rights: Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request Plan materials 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 that is denied or ignored, in whole or in part, you may file suit in 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.

Assistance with your questions: If you have any questions about the Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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, N.W., Washington, D.C. 20210. You may also 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.

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 Program. 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 Program, 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 Claim Administrators' authority, see the Plan Document and *Appendix A. Claims Procedures*.

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.

No Government Guarantee of Welfare Benefits

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

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 contained in the Plan Document.

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

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

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, then under the

terms of the Plan 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:

1. 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;
2. 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
3. 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 *Appendix A. Claims Procedures*, 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 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.

Class Action Lawsuits

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

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 ("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, 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, 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.

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.

Providing Notice to Administrator

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.

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.

Incompetent and Deceased Participants

Except as otherwise provided in an applicable Incorporated Document:

- If the Administrator determines that a Participant is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Program, the Administrator may make benefit payments to the court-appointed legal guardian of the Participant, to an individual who has become the legal guardian of the Participant by operation of state law, or to another individual whom the Administrator determines is the appropriate person to receive such benefits on behalf of the Participant.
- Payments due to deceased Participants from claims made under a Program shall be made to the Participant's estate.

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, the Program'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 Plan Administrator is entitled to rely on the last address provided to the Program by you, and has no obligation to search for or ascertain your whereabouts.

For More Information

If you have questions, contact the Retiree Service Center at 1-800-344-0661 or access the Dow Benefits website and click on Message Center.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for The Dow Chemical Company Long Term Disability Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008) (the "Plan"). However, this booklet is not all-inclusive and it is not intended to take the place of the Plan's legal documents.

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

The Plan Document can be made available for your review upon written request to the Plan Administrator (listed in the ERISA Information section of this Summary Plan Description). 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.

ERISA Information

The Dow Chemical Company
Long Term Disability Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008)
ERISA Plan #506
(A Welfare Benefit Plan)

Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 (800) 344-0661
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 LTD Plan (800) 344-0661
Type of Plan	Long-term disability insurance
Type of Plan Administration	Insurer administration
Employer Identification Number	38-1285128
Plan Number	506
Group Policy Number	27475-G
To Serve Legal Process	General Counsel The Dow Chemical Company Corporate Legal Department Global Dow Center 2211 H.H. Dow Way Midland, MI 48674

Claims Administrator for Claims for Plan Benefits	*To submit a Claim for Plan Benefits:* MetLife Group Long Term Disability Claims P.O. Box 14590 Lexington, KY 40511-4590 *To appeal a denied Claim for Plan Benefits:* MetLife Disability P.O. Box 14592 Lexington, KY 40511-4592 Attention: Claims Administrator for The Dow Chemical Company Long Term Disability Program Applicable to Those Who Were Fully Disabled Prior to January 1, 2008 (Appellate Review)
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 Administrator 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 LTD Plan (Eligibility Determination) (800) 344-0661 *Appeals Administrator:* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Appeals Administrator for LTD Plan (Eligibility Determination) (800) 344-0661
Plan Year	The Plan's fiscal records are kept on a plan year beginning January 1 and ending December 31.
Funding	Dow paid the premium for the 50 percent benefit. Employees paid for some or all of the cost of the additional optional 16.7 percent benefit. Plan benefits are funded by a group insurance contract with MetLife. Any assets of the Plan may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as the Plan may be amended from time to time, as well as to pay for any expenses of the Plan. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses.

Appendix A.
Claims Procedures

You Must File a Claim in Accordance with these Claims Procedures

A "Claim" is a written request by a claimant for *Plan Benefits* or an *Eligibility Determination.* There are two kinds of Claims:

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

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 Eligibility Determination* for the procedures regarding Claims for Eligibility Determinations.

Deadline to File a Claim and File Proof of Claim

Claims for Plan Benefits

You must file a Claim for Plan Benefits within nine (9) months after the Full Disability (also called the Phase 1 Disability), and you must file your proof of the Full Disability within 18 months after the **beginning** of the Full Disability, otherwise your Claim for Plan Benefits will be denied (unless there are extenuating circumstances as determined by the Claims Administrator).

Claims for an Eligibility Determination

You must file a Claim for an Eligibility Determination no later than one (1) year after your last day on the payroll of Dow.

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 MetLife.

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 a 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.

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.

Proof of Disability

If you are being paid monthly LTD benefits, the Plan has the right to request proof of Full Disability or Total Disability, whichever is applicable, as often as it reasonably chooses. While LTD benefits are being claimed under the Plan, you must provide proof that you continue to be:

- Fully Disabled during the Primary Benefit Period (Phase 1), and
- Totally Disabled during the Secondary Benefit Period (Phase 2).

Monthly Benefits will not be paid with respect to Full Disability or Total Disability:

- if you fail to provide proof that is satisfactory to MetLife when you file a Claim for Plan Benefits;
- if you fail to provide proof, when MetLife asks for it, that such disability exists and/or continues to exist; or
- for any period of time during which you are not under the care of a doctor for that Full Disability or Total Disability.

For further information please see the Certificate of Insurance. If MetLife informs you that you do not have sufficient proof of disability, you should discuss the situation with your physician as soon as possible to make sure that MetLife is provided all the information that it needs to make a decision on your Claim.

A statement from a physician without objective evidence may not be sufficient proof of Full Disability or Total Disability. It is strongly recommended that you work with your doctor to make sure that MetLife is presented with all available evidence (*e.g.*, medical examination, tests) to support your Claim to MetLife that you meet the definition of Full Disability. For example, a current medical examination and tests should be obtained near in time to the date you file your Claim for Full Disability to show the current status of your disability. Medical examinations and tests by your treating physician are not paid for by the LTD Plan.

A decision by your employer that you cannot perform the essential functions of your job with or without reasonable accommodation is independent of MetLife's decision as to whether you meet the Full Disability definition, and is based on different criteria and requirements of proof than the Full Disability determination by MetLife.

Airplane pilots in Dow's Aviation Department who fail, because of their health, to pass the Class II F.A.A. health examination and who have been certified by the Participating Employer as not having been redeployed to another job with a Participating Employer will meet the definition of Fully Disabled. MetLife shall accept the following as proof of such pilot's Full Disability: (1) evidence of the pilot's failure, because of health, to pass the Class II F.A.A. health examination, and (2) the Participating Employer's certification that the pilot has not been redeployed to another job with a Participating Employer.

Airplane pilots should note that failure to pass the Class II F.A.A. health examination and certification by the Participating Employer will not by itself satisfy proof of Total Disability for the Secondary Benefit Period (Phase 2). You must also meet the definition of Total Disability for the Secondary Benefit Period (Phase 2).

Claims for Eligibility Determinations

Information Required In Order to Be a "Claim"

For Claims that are requests for *Eligibility Determinations*, the Claims must be in writing and contain the following information:

- The name of the Employee, and
- The name of the plan for which the Eligibility Determination is being requested.

Claims for Eligibility Determinations must be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Initial Claims Reviewer for Long Term Disability Program Applicable to Those Fully Who Were Disabled Prior to January 1, 2008 (Eligibility Determination)

Initial Determination

If you submit a Claim for an Eligibility Determination, the Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer may have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer needs such an extension, it will notify you prior to the expiration of the initial 90-day period, state the reason why such an extension is needed, and state when it will make its determination. If the Initial Claims Reviewer denies the Claim, the written notification of the Claims decision will state the reason(s) why the Claim was denied and refer to the pertinent Plan provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer needed additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

Appealing the Initial Determination

If the Initial Claims Reviewer 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. Your written appeal must include the following information:

- Employee's name,
- The relationship of the person requesting an Eligibility Determination to the Employee,
- Name of the Plan,
- Reference to the Initial Determination, and
- Explanation of the reason why you are appealing the Initial Determination.

Appeals of Eligibility Determination Claims should be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for Long Term Disability Program Applicable to Those Who Were Fully Disabled Prior to January 1, 2008 (Appeal of Eligibility Determination)

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

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

The Appeals Administrator 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 may have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator 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 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 Plan, and provide you with the deadline for submitting such information. The period for deciding your Claim may, in the Appeals Administrator's sole discretion, 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 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 of ERISA.

Claims for Plan Benefits

If you want to file a Claim for Plan Benefits, you must complete a MetLife claims form and provide documentation showing that you were Totally Disabled during and for the time required under the Plan. See the *Proof of Disability* section, above. Contact the Retiree Service Center at:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Plan Administrator for Long Term Disability Program Applicable to Those Fully Disabled Prior to January 1, 2008
(800) 344-0661

The Plan Administrator will review and sign your completed MetLife claims form and forward the form and documentation to:

MetLife Disability
P.O. Box 14590
Lexington, KY 40511-4590

Initial Determination

When you submit a Claim for Plan Benefits to the Initial Claims Reviewer for Claims for Plan Benefits, 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. 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.

Such notification will be provided to you within a reasonable period, not to exceed 45 days after the date you submitted your Claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case 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.

For Claims Filed on or before April 1, 2018

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

1. The specific reason or reasons for denial of the Claim;
2. References to the specific Plan provisions upon which such denial is based;
3. An explanation of the Plan's appeal procedures and the applicable time limits;

4. A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
5. If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request;
6. If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
7. A statement of your right to bring a civil action under section 502(a) of ERISA, if your Claim is denied upon review.

For Claims Filed after April 1, 2018

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

1. The specific reason or reasons for denial of the Claim;
2. References to the specific Plan provisions upon which such denial is based;
3. A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
4. An explanation of the Plan's appeal procedures and the applicable time limits;
5. 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);
6. 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;
7. 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;
8. 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
9. A statement of your right to bring a civil action under section 502(a) of ERISA if your Claim is denied upon review.

Appealing the Initial Determination

If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. In addition, if you were being paid benefits and you have been notified that these benefits will be terminated, you may also appeal the decision to terminate your benefits. 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:

- Name of Employee,
- Name of the Plan,
- Reference to the Initial Determination, and
- Explanation of the reason why you are appealing the Initial Determination.

Send your appeal to:

MetLife Disability
P.O. Box 14592
Lexington, KY 40511-4592
Attention: Claims Administrator for The Dow Chemical Company Long Term Disability Program Applicable to Those Fully Disabled Prior to January 1, 2008 (Appellate Review)

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 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:

1. The specific reason or reasons why the Claim you appealed is being denied;
2. References to the specific Plan provisions on which the denial is based;
3. 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;
4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about the voluntary appeal procedures;
5. 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);
6. 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;

7. 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

8. 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 B.
Definitions

See Plan Document for additional definitions. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

"**Active at Work Requirement**" means:

1. For Option 1 benefits, the "Active at Work Requirement" requires that on any date that the Employee's personal benefits under Option 1 are to become effective, the Employee must be actively at work with the Participating Employer for at least one day of his or her regularly scheduled work hours in order for those benefits to take effect.
2. For Option 2 benefits, the "Active at Work requirement" requires that on any date that the Employee's personal benefits under Option 2 are to become effective, he or she must be actively at work as an Employee on that date and have been actively at work as an Employee for the 30 days immediately preceding that date in order for those benefits to take effect.

"Active Work" or **"Actively at Work"** means that a person is working for the Participating Employer and is physically and mentally able to perform the normal duties of the job.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Plan Benefits, MetLife. 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*.

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

"**Claim for an Eligibility Determination**" means a Claim requesting a determination as to whether a claimant is eligible to enroll in one of the Plans or the Program 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 Internal Revenue code of 1986, as amended.

"Company" means The Dow Chemical Company, a corporation organized under the laws of Delaware.

"Disability" means either "Full Disability" or "Total Disability"

"Dow" means a Participating Employer, or collectively, the Participating Employers, as determined by the context in which it is used. "Dow" and "Participating Employers" have the same meaning and are used interchangeably.

"**Dow Employees' Pension Plan**" means The Dow Employees' Pension Plan, of which there are two components: (1) the DEPP component, and (2) the Personal Pension Account component.

"Elimination Period" means, with respect to a Period of Disability, the later of:

a. the first 6 months that you are Fully Disabled and/or Totally Disabled, or

b. the date you are no longer receiving payroll income from the Company's payroll department.

"Employee" means a person who:

a. is employed by a Participating Employer to perform personal services in an employer-employee relationship which is subject to taxation under the Federal Insurance Contributions Act or similar federal statute; and

b. receives payment for services performed for the Participating Employer directly from the Company's U.S. Payroll Department, or a Participating Employer's U.S. Payroll Department; and

c. if on an international assignment, is either a U.S. citizen or Localized in the U.S.

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

a. 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;

b. 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;

c. an individual whom is classified or treated as an independent contractor; or

d. 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 you are not an "Employee", you will not be eligible to participate in the Plan, regardless of whether the determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. Any change to your status by reason of reclassification will apply prospectively only (*i.e.*, will apply to benefits that are payable, under the terms of the Plan, after your reclassification).

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

"Full Disability" or **"Fully Disabled"** means you cannot, because of sickness or an injury, perform your regular job or any other reasonably appropriate job your Participating Employer can provide. Full Disability may also be called "Phase 1 Disability".

"Full-Time" Employee means an Employee who has been classified by a Participating Employer as having "full-time" status.

"Hourly Employee" or **"Bargained for Employee"** means an Employee who is represented by a collective bargaining unit that is recognized by the Company or other Participating Employer and whose bargaining unit has agreed to this Program.

"Initial Claims Reviewer" means, with respect to deciding Claims for a Plan Benefit, MetLife. 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*.

"Less-Than-Full-Time" Employee means an Employee who has been approved by a Participating Employer to work 20 to 39 hours per week and is classified by a Participating Employer as having "less-than-full-time status".

"Localized" occurs when an individual has been determined by a Participating Employer to be permanently relocated to a particular country, and the individual has accepted such determination. For example, an Employee who is a Malaysian national is "Localized" to the U.S. when a Participating Employer has determined that such Employee is permanently relocated to the U.S., and such Employee has accepted such determination.

"Married" or **"Marriage"** 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 is "Married" for purposes of the Plans 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 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.

The Plan does not recognize common law marriages except that:

a. if an Employee or Retiree was a participant of either the Program of The Dow Chemical Company Medical Care Program prior to November 1, 1993, and had a common law spouse recognized under the laws of the state in which they resided prior to November 1, 1993, and if the common law spouse was covered as a dependent under the Program prior to November 1, 1993, then such common law spouse is deemed under the Program to be Married to the Retiree; and

b. effective January 1, 1996, the Plan recognized a marriage which meets the requirement of Texas Family Code Annotated s.1.91(a)(1); and

c. effective January 1, 2002, common law spouse of Union Carbide Corporation (UCC) employees and former UCC employees who were covered under a UCC medical plan at any time between February 6, 2001 and December 31, 2001 as "spouses" of UCC employees will be deemed to be "Married" for purposes of this Plan.

"MetLife" means Metropolitan Life Insurance Company.

"Option 1" means the Plan option that provides a 50% benefit and is provided at no cost to the eligible Employee.

"Option 2" means the Plan option with the optional 66.7% benefit if such plan is offered by a Participating Employer.

"Participant" each Employee or such other individual who, in accordance with Program, is eligible to participate in the Program, elects to participate in the Program, and remains eligible for benefits under the Program..

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

"Period of Disability" means any one continuous period of time during which you are Fully Disabled and/or Totally Disabled because of one or more causes. If you return to active work with the Participating Employer after a Period of Disability for which monthly benefits have been paid under the Plan, successive Periods of Disability, due to the same or related cause or causes, which:

1. start while you are covered for Long Term Disability Benefits; and
2. are separated by less than 6 continuous months of active work with the Participating Employer on a full-time basis;

will be considered as one continuous Period of Disability.

"Phase 1 Disability" means "Fully Disabled" or "Full Disability".

"Phase 2 Disability" means "Totally Disabled" or "Total Disability".

"Plan" means the Long Term Disability Program Applicable to Those Fully Disabled Prior to January 1, 2008 (ERISA Plan #506). The term "Plan" and the term "Program" are interchangeable, as they have the same meaning.

"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 plan document for the Plan. The Summary Plan Description for the Plan is an integral part of the Plan Document.

"Plan Year" means the 12-consecutive-month period beginning each January 1 and ending each December 31.

"PPA" means the Personal Pension Account component of The Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, whichever is applicable.

"Primary Benefit Period" or **"Phase 1"** or **"First Phase"** means with respect to a Period of Disability, the period of time, if any, which starts on the day after the end of the Elimination Period and which ceases on the earliest of:

1. the day 24 months after that Elimination Period ends; and
2. the day that your Period of Disability ends; and
3. your Terminal Date.

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

"Retire" or "Retirement" means when an active Employee who is age 50 or older with at least 10 years of Service terminates employment with a Participating Employer, and is also a "retiree" under the terms of the DEPP component of the Dow Employees' Pension Plan or the UCEPP component of the Union Carbide Employees' Pension Plan.

"Retiree" means a former Employee who was age 50 or older with at least 10 years of Service when his or her employment terminated with a Participating Employer and who is also a "retiree" under the terms of the DEPP component of the Dow Employees' Pension Plan or the UCEPP component of the Union Carbide Employees' Pension Plan.

"Salaried" means an individual who is not represented by a collective bargaining unit.

"Secondary Benefit Period" or **"Phase 2"** or **"Second Phase"** means, with respect to a Period of Disability, the period of time, if any, which starts on the day after the end of a Primary Benefit Period and ceases on the earlier of:

1. your Terminal Date; and
2. the day that Period of Disability ends.

"Service" is as defined in the SPD, depending on the context in which the term is used.

"Spouse" means a person who is Married to the Employee.

"SPD" means the Summary Plan Description. The SPD is an integral part of the Plan Document for the Plan.

"Terminal Date" means the date the Participant's Monthly Benefits end. If you have been approved for LTD benefit payments and are receiving LTD benefit payments, your LTD benefit payments will end when any *one* of the following applies to your situation:

1. You reach age 65, if your Full Disability or Total Disability began before age 60.
2. After 60 consecutive months of benefit payments, or when you reach age 70, whichever is earlier, if your Full Disability or Total Disability began between ages 60 and 69.
3. After 12 consecutive months of benefit payments, if your Full Disability or Total Disability began between ages 70 and 74.
4. After 6 consecutive months of benefit payments, if your Full Disability or Total Disability began on or after age 75.
5. If you begin receiving pension benefits under the Dow Employees' Pension Plan, (including its DEPP and PPA components). If your Full Disability or Total Disability began on or after February 7, 2003, LTD benefits end if you begin receiving pension benefits under the Union Carbide Employees' Pension Plan (including its UCEPP and PPA components).
6. After 12 consecutive months of benefit payments, if you had not completed one year of continuous service as an Employee.
7. If you no longer meet the definition of Full Disability for the Primary Benefit Period, or you no longer meet the definition of Total Disability for the Secondary Benefit Period.
8. You receive disability payments from any other long term disability plan sponsored by The Dow Chemical Company or its subsidiaries or affiliates.

"Total Disability" or "Totally Disabled" means the Participant cannot, because of a sickness or an injury:

a. do his or her job; and
b. do any other job for which he or she is reasonably fit by his or her education, training or experience (including work with a Participating Employer, self-employment or work with another employer).

"UCEPP" means the Union Carbide Employees' Pension Plan, formerly known as the Retirement Program Plan for Employees of Union Carbide Corporation and its Participating Subsidiary Companies.

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

Appendix C.
Named Fiduciaries as of April 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 April 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 833-693-6947 or visit www.dowbenefits.com.

Named Fiduciary	Dow Title	Named Individual	Effective Date
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Jamye Gallihugh	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Elaine Rabideau	April 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