Summary Plan Description for:

The Dow Chemical Company
Voluntary Group Accident Insurance Plan

APPLICABLE TO
ELIGIBLE EMPLOYEES

ERISA Plan #504

Effective January 1, 2019 and thereafter until superseded

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

Copies of updated SPDs (including this SPD) are available at the Dow Benefits & Well-being website (www.dowbenefits.com), by requesting a copy from HR Solutions (833-693-6947), 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.

Content Steward: Gerisch
January 1, 2019
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Section 1. ERISA Information

Voluntary Group Accident Insurance	
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 (833) 693-6947
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 VGA Plan (833) 693-6947
Type of Plan	Accident insurance
Type of Plan Administration	Insurer administration
Employer Identification Number	38-1285128
Plan Number	504
Group Policy Number	PAI-9900841A
To Serve Legal Process	VGA Plan Administrator at the above address or: The Dow Chemical Company General Counsel Corporate Legal Department 2211 H.H. Dow Way Midland, MI 48674
Claims Administrator for Claims for Plan Benefits	National Union Fire Insurance Company of Pittsburgh PA (NUFIC), an AIG company: NUFIC Accident and Health Claims Division P. O. Box 25987 Shawnee Mission, KS 66225-5987 1-800-551-0824
Claims Administrator for a Claim for an Eligibility Determination	The Claims Administrator for a Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Documents. The person, group of persons, or entity designated as Claims Administrators for a Claim for

	an Eligibility Determination is listed in *Appendix C. Named Fiduciaries*. The address and phone number for the Claims Administrators for a Claim for an Eligibility Determination are: *Initial Claims Reviewer:* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Initial Claims Reviewer for the VGA Plan (Eligibility Determination) (833) 693-6947 *Appeals Administrator:* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Appeals Administrator for the VGA Plan (Eligibility Determination) (833) 693-6947
Plan Year	The Plan's fiscal records are kept on a plan year beginning January 1 and ending December 31 of each year.
Funding	Employees pay the premiums for Plan coverage. Benefits under the Plan are insured through a group insurance contract with National Union Fire Insurance Company of Pittsburgh PA (NUFIC). Benefits, if any, that are not paid through a group insurance contract are paid from the Company's or Participating Employer's general assets. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from assets of the Plan, if any.
Joint Insurance Agreement	Dorinco Reinsurance Company ("Dorinco") and NUFIC have entered into an arrangement approved by the U.S. Department of Labor pursuant to Prohibited Transaction Exemption 85-108, Exemption Application No. D-6057, in which NUFIC has or will write the coverage for the Plan and Dorinco will assume a percentage of the risk. Dorinco is a subsidiary of the Company. Under the insurance arrangement between NUFIC and Dorinco, NUFIC and Dorinco will each be liable to pay the agreed upon percentage of each claim in respect of a Plan Participant. When a Claim for Plan Benefits is approved, Dorinco transfers its percentage of the claim to NUFIC, and NUFIC pays the full amount of the claim. If Dorinco is financially unable to pay its designated percentage of a particular claim, NUFIC is obligated to pay the entire amount of the claim. Neither NUFIC nor Dorinco will charge the Plan any administrative fees, commissions or other consideration as a result of the participation of Dorinco.

Section 2. Introduction

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Voluntary Group Accident Insurance Plan (the "Plan"). The provisions of this SPD apply only to active employees and certain disabled individuals and may be subject to provisions in an applicable collective bargaining agreement. The provisions of this SPD apply to Covered Accidents that occur on or after January 1, 2019, unless an earlier effective date is indicated.

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

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

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

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

Capitalized words in this SPD are defined either in the Plan Document or in *Appendix A. Definition of Terms*. References in this SPD to the "Company" mean The Dow Chemical Company, and references to "Participating Employer" or "Dow" mean the Company or any other corporation or business entity the Company authorizes to participate in the Plan. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Section 3. Plan Provisions

3.1 Eligibility

3.1.1 Employee Eligibility.

Salaried Employees

You are eligible to enroll in Plan coverage if you are an active, Regular, Full-Time or Less-Than-Full-Time Salaried Employee of a Participating Employer, or are receiving partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008).

Hourly Employees

Except as otherwise provided in the applicable collective bargaining agreement, you are also eligible if you are an active, Regular, Full-Time, Bargained-for Employee of Dow, or are receiving partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008), and your Bargaining Unit and Participating Employer have agreed to the Plan. However, if the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Plan, then the terms of such collective bargaining agreement shall govern as to whether an Employee is eligible.

Employees on a Leave of Absence

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by a Participating Employer, such as an approved leave under the Company's Military Leave Policy, Family Leave Policy or Medical Leave Policy, or unpaid leave policy or a period during which you receive partial disability payments under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008). The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. You must continue making any required contributions in order to keep your coverage in effect. The contributions must be paid by payroll deduction (if available) or any other means the Plan Administrator deems appropriate or necessary to collect the contributions.

The Plan Document may contain other eligibility provisions for special groups of people. See the Plan Document for details.

3.1.2 Family Eligibility. If you are enrolled for coverage in the Plan, then your Spouse/Domestic Partner is also eligible for Plan coverage, except that, if your Spouse/Domestic Partner is a Dow Employee, you may not enroll your Spouse/Domestic Partner as a Dependent. Instead, your Spouse/Domestic Partner must enroll in the Plan separately as a Dow Employee.

Your Dependent Child(ren) is(are) automatically covered at no additional cost if you are enrolled in the Plan.

A Dependent Child is defined as a child who is principally supported by you, and includes:

- Any natural child;
- Any legally adopted child;
- Any foster child;
- Any step-child who permanently resides in your household;
- Any child for whom you or your Spouse/Domestic Partner is the legal guardian, who permanently resides in your household.

Coverage for Dependent Children who meet the above criteria begins on their date of birth or date of placement in your home, if later, and continues until the 19th birthday. Dependent Children may continue coverage until their 26th birthday as long as they are full-time students at an accredited institution of higher learning. A child who is physically or mentally incapable of self-support upon attaining 19 years of age may continue coverage under the Plan while remaining incapacitated and unmarried for as long as you are covered by the Plan. Contact HR Solutions at least 31 days before the Child's 19th birthday if this applies to you.

3.1.3 Documentation of Dependent Eligibility. The Plan reserves the right, at any time, to request proof of Dependent eligibility, such as birth certificates, passports, Marriage certificates, Domestic Partner signed statements, or any other form of proof the Plan Administrator deems appropriate. ***Failure to provide proof of eligibility within the time required will result in no coverage and/or will result in retroactive cancellation of coverage. If this occurs, you may be required to reimburse the plan for any Plan benefits the Plan has paid.***

3.1.4 Corporate Pilots. Coverage includes all Employees classified as Corporate Pilots of Dow while they are performing, learning to perform, or instructing others to perform as a

licensed pilot or crew member of an approved aircraft that is owned, leased, chartered or rented by Dow and is being operated at the time on Dow business.

3.1.5 Rohm and Haas Company Disability Participants. If you were a Rohm and Haas Company or Morton International, Inc. Employee who was approved for and is receiving disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible under the Plan for the amount of accidental death and dismemberment coverage that you were enrolled in immediately prior to your disability if your qualifying disability was incurred before:

- October 1, 2009, for Morton International, Inc. Employees; or
- January 1, 2010, for Rohm and Haas Company Employees.

If you are eligible for Plan coverage, you remain eligible until you are no longer eligible for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. You must pay the premiums required for this coverage.

Employees who have been approved for Disability Retirement under Rider 4 of the Rohm and Haas Company Retirement Plan (formerly, the Morton International, Inc. Pension Plan for Collectively-Bargained Employees) (the "Legacy Morton CBE Plan") are eligible under the Plan for the amount of Company-paid accidental death and dismemberment coverage that they were enrolled for immediately prior to their Disability Retirement. This coverage continues until they no longer qualify for Disability Retirement under the Legacy Morton CBE Plan.

3.1.6 Eligibility Determinations of Claims Administrator are Final and Binding. The Claims Administrator for Claims for an Eligibility Determination determines eligibility to participate in the Plan. The Claims Administrator is a Plan fiduciary and has the full discretion to interpret the eligibility provisions of the Plan and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants (except to the extent that determinations by the Initial Claims Reviewer are subject to review by the Appeals Administrator). 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, you must follow the procedures described in *Appendix B. Claims Procedures*.

3.2 Enrollment

3.2.1 Enrollment Process and Timing of Coverage. To obtain Plan coverage, enroll during the annual enrollment period or go to the Dow Benefits enrollment website at www.dowbenefits.ehr.com. If you do not have internet access, HR Solutions can provide assistance. You may enroll:

- On or before your employment date, in which case coverage begins as of the later of the date your enrollment is received by the Plan Administrator or your first day at work.
- Within 90 days of your first day of active employment, in which case coverage begins as of the date that your enrollment is received by the Plan Administrator.
- Within 90 days of a change in your personal status (see Section 3.2.3, below, regarding change in status).
- During the annual enrollment period, in which case coverage begins as of January 1st. If at annual enrollment you fail to enroll or affirmatively waive coverage under

the Plan, your current Plan election will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible.

Note: When you are enrolled, your Dependent Child(ren) automatically is (are) enrolled at no additional cost.

If you became an Employee of a Participating Employer as part of the Separation of Dow Inc. from DowDuPont Inc., you were enrolled in the closest level of coverage to what you had at DowDuPont Inc. You had 31 days from your start date to change your coverage.

3.2.2 Reduction of Certain Benefit Elections to Prevent Discrimination. The Plan Administrator has the authority to change the benefit elections of certain Participants if such a change is necessary to prevent the Plan from becoming discriminatory within the meaning of Section 125(b) of the Internal Revenue Code (the "Code"). If the Plan Administrator determines, or is informed by the plan administrator of The Dow Chemical Company Flexible Spending Plan (the "Flexible Spending Plan"), before or during any Plan Year, that the Flexible Spending 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 (each as defined in Section 125 of the Code), the Plan Administrator will 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 key employees or highly compensated employees with or without the consent of such employees.

3.2.3 Change in Status. In general, you purchase your Employee and Spouse coverage under the Plan with premiums that are pre-tax dollars through the Flexible Spending Plan, a plan intended to qualify under Code Section 125 as a "cafeteria plan." You may change your Plan coverage only during annual enrollment, or if you have a "change in status" and you meet all of the consistency rules (as required by the terms of the Flexible Spending Plan).

Because of IRS rules, Domestic Partner coverage is generally purchased with post-tax dollars.

For purposes of the Flexible Spending Plan, a "change in status" is an event listed in one of the bullets below:

- An event that changes your legal marital/domestic partner status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner, divorce, annulment, or Termination of Domestic Partnership.
- An event that changes your number of Dependents, including birth, adoption, placement for adoption, or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse/ Domestic Partner or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse/ Domestic Partner or Dependent Child.
- Your Dependent Child satisfies or ceases to satisfy the definition for "Dependent Child."
- Your Spouse/Domestic Partner gains eligibility for coverage under the Spouse/ Domestic Partner's employer's voluntary group accident plan.

In addition to having a "change in status," all of the following consistency rules must be met:

- The change in status must ***result*** in you, your Spouse/Domestic Partner, or your Dependent Child ***gaining or losing*** eligibility for coverage under either the Plan or the parallel plan of your Spouse/Domestic Partner or Dependent child's employer.
- The election change to the Plan must ***correspond with*** that gain or loss of coverage.

The Plan administers change in status events and the consistency rules the same way with respect to Domestic Partners as Spouses, regardless of the post-tax treatment by the IRS, to the extent that such administration does not jeopardize the tax-qualified status of the Plan.

3.2.3.1 Enrollment Deadline for Mid-Year Changes. If you meet the requirements allowing you to make a mid-year election change, you must submit proof of eligibility and enroll through the Dow Benefits website (or call HR Solutions to enroll) within 90 days of the change in status event. If the Plan Administrator receives your enrollment and proofs within 31 days of the change in status event, the effective date of change in coverage will be the date of the event. If the Plan Administrator receives your enrollment and proofs on day 32 through 90 (or day 32 through 180 for relocation) after the change in status event, the effective date of the change in coverage will be the Plan Administrator's processing date.

3.2.3.2 Required Documentation. Documentation is required to show proof of eligibility to make an election change and/or to show proof of Dependent eligibility. Required documentation may include birth certificates, passports, Marriage certificates, Domestic Partner signed statements, Social Security numbers, a court order evidencing legal separation, evidence of loss of Spouse/Domestic Partner or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Plan reserves the right to, at any time, request proof of eligibility. ***Failure to provide proof of eligibility within the time required will result in no coverage and may result in retroactive cancellation of coverage. If this occurs, you may be required to reimburse the Plan for any payments for benefits already paid by the Plan.*** Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentations. See Section 3.9 of this SPD regarding fraud.

3.2.4 Ending Coverage. Coverage under the Plan ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Employee elects not to participate for the Plan Year
- Date that required premiums are due but not paid
- Death
- The Employee Retires
- The Employee begins receiving benefits under The Dow Chemical Company Long Term Disability Program (Applicable to Those Actively at Work on or after January 1, 2008) (ERISA Plan #606)

- The Employee takes a leave of absence (other than certain leaves of absences described in Section 3.1.1 or the Plan Document and other unique situations specified in the Plan Document)
- The Employee terminates employment with Dow or the Participating Employer
- The date your employer ceases to be a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code
- Workstoppage

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

You may cancel Plan coverage during the annual enrollment period with the change effective on January 1st of the following year. In addition, you may cancel coverage within 90 days of a change in status.

Note: When ending coverage for your Spouse/Domestic Partner, you must complete a new enrollment within 90 days to reduce your payroll deductions. The Plan Administrator reserves the right to determine that your Spouse/Domestic Partner or Dependent Child was not covered under the Plan retroactive to the actual date of eligibility loss. The Plan reserves the right not to refund premiums you paid and to cancel coverage of your Spouse/Domestic Partner or Dependent Child retroactive to the date of loss of eligibility.

3.2.5 Coverage Amounts.

Insured Person	Coverage in Increments of	Minimum Amount	Maximum Amount
Employee	$10,000	$10,000	$500,000
Spouse/Domestic Partner of Employee	$10,000	$10,000	$250,000
Rohm & Haas Company Disability Participant*	$10,000	$10,000	$100,000
Spouse/Domestic Partner of Rohm & Haas Company Disability Participant*	$10,000	$10,000	$50,000

* Rohm & Haas Company Disability Participants are eligible only for the amount of Plan coverage for which they were eligible and enrolled immediately prior to their disability. Such coverage may be in a different increment than shown above or subject to a lower maximum.

If you are insured under the Plan, your Dependent Child is covered under the Plan automatically. Only one benefit is payable per child, and the benefit is based on the parent

insured for the greater amount of coverage. The amount of Dependent Child coverage is limited to:

- ten (10) percent of an Employee's or his or her Spouse/Domestic Partner's coverage amount, whichever is greater, up to a $10,000 maximum for each Dependent Child; or
- twenty (20) percent of a Rohm & Haas Company Disability Participant's coverage amount, up to a maximum of $20,000.

Plan benefits are paid in addition to any other insurance benefits you receive, except for the Repatriation of Remains benefit (see the Repatriation of Remains in section 3.4.15 of this SPD). Generally, your benefit will be paid in a lump sum according to your injury and coverage amount. Benefits are payable for a covered loss that occurs within 365 days following an accidental injury.

3.3 Contributions

Your premium for Plan insurance is based on the amount of coverage you select for Employee and Spouse/Domestic Partner coverage. In general, the premium for Employee and Spouse coverage is payable in pre-tax dollars, and the premium for Domestic Partner coverage is deducted on a post-tax basis. NUFIC may change the required premiums due in accordance with the terms of the Policy.

If you are on a leave of absence approved by the Participating Employer that provides eligibility under this Plan, the Plan Administrator has the discretion to make special administrative arrangements as are necessary to collect the premium. Such arrangements may include deferring your contributions on a temporary basis during the leave of absence, and requiring you to pay "catch-up" premiums when you return to work, or any other arrangement the Plan Administrator deems appropriate.

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

3.4 Coverage Provisions

The amount of coverage you select is called the Principal Sum. If you, your insured Spouse/Domestic Partner or Dependent Child incur any of the following losses within 365 days of a Covered Accident, the Plan will pay a percentage of the Principal Sum as listed in the table below, provided that Spouses, Domestic Partners, and Dependent Children are not eligible for Plan benefits on account of permanent and total disability. Benefits are paid in U.S. dollars.[1] The U.S. dollar amount is based on the percentage of Principal Sum payable and the annual base salary and currency exchange rate, determined as of the date of the Covered Accident. If you are on an expatriate assignment, the U.S. dollar amount is based on the percentage of Principal Sum payable, and the annual base salary in home-country currency and the currency exchange

[1] If a benefit cannot be paid in U.S. dollars due to local laws, the benefit will be paid by the Participating Employer in local currency so as to comply with applicable law; provided that the Participant and/or the beneficiary, whichever is applicable, waives any and all of his or her rights to receive a benefit from the Plan or the insurance carrier. Such payment will be converted to local currency using the exchange rate in effect at the payor bank designated by the Participating Employer on the date the payment is issued to the beneficiary. By a separate agreement between the Plan Sponsor and the insurance carrier, the Participating Employer will then be reimbursed by the insurance company.

rate, determined as of the date of the Covered Accident. The home-country annual base salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

Please note that if a benefit is payable for a loss suffered by an Insured Person whose permanent, current place of primary residence is outside the U.S. or Canada, NUFIC will pay the benefits to the Participating Employer, and the Participating Employer will transmit such benefits (reduced as described in the next sentence) to the Insured Person or the Insured Person's beneficiary. ***If the Participating Employer must pay a tax in connection with the transmittal of such benefits, the amount of the benefit payable to the Insured Person or the Insured Person's beneficiary will be reduced by the amount of taxes that the Participating Employer must pay.***

3.4.1 Table of Losses

	Maximum Percentage of Principal Sum:
Loss of:	
Life	100%
Both Hands or Both Feet	100%
Total Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Total Sight of One Eye	100%
One Foot and the Total Sight of One Eye	100%
Speech and Hearing in both ears	100%
One Hand or One Foot	50%
Total Sight of One Eye	50%
Speech or Hearing in both ears	50%
Hearing in one ear	25%
Thumb and Index Finger of the Same Hand	25%
Paralysis:	
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%
Coma	1% per month for 100 months or until the coma ends, if earlier
Severe Burn:	
Specified Body Area—	
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint	22.5%
Upper Arm Below Shoulder Joint to Elbow Joint	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints	36%
Thigh Below Hip Joint to Knee Joint	9%
Foot and Lower Leg Below Knee Joint	27%

	Maximum Percentage of Principal Sum:
Permanent Total Disability[2]	100%

3.4.2 Coma. If injury renders you or your covered Spouse/Domestic Partner or Dependent Child comatose within 365 days from the date of a Covered Accident that caused the injury, and if the coma continues for a period of at least 30 consecutive days, the Plan will pay a monthly coma benefit. The monthly amount will equal 1% of the Principal Sum, less any other amount paid or payable under this Policy as a result of the same accident. If the coma ends in the middle of a month, the Plan will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day of coma that falls between full months. This benefit will be paid each month the coma continues, for a maximum of 100 months or until the coma ends, whichever occurs first.

3.4.3 Common Disaster. If you as a covered Employee have selected coverage for your Spouse/Domestic Partner and both of you are involved in a Covered Accident that results in the loss of both lives within 90 days of the accident, your Spouse/Domestic Partner's Principal Sum Benefit will be increased to equal your Principal Sum. For example, if you are insured for $150,000 and your Spouse/Domestic Partner is insured for $100,000, the Principal Sum for your Spouse/Domestic Partner will increase to $150,000 under this provision.

3.4.4 Conversion to Individual Policy. If you become ineligible for coverage under this Plan (prior to age 70), you may elect to convert the accidental death and dismemberment portion of your existing coverage to an individual policy. No evidence of insurability is required to obtain the individual policy. The converted insurance must be at least $100,000 and cannot exceed the greater of (1) the amount of your existing coverage; or (2) $500,000. If the accidental death and dismemberment portion of your existing coverage is less than $100,000, you may elect to convert the coverage to an individual policy of $100,000. Coverage for your Spouse/Domestic Partner or Dependent Child may be converted only if he or she is the age of majority or over on the date the coverage ends. The insurance company must receive your application and premium payment within 31 days of losing eligibility in order to convert the insurance. Contact NUFIC's general agent (Reuben Warner Associates, telephone 800-421-3005) to obtain enrollment information.

3.4.5 Day Care. If you or your covered Spouse/Domestic Partner die in an accident where a death benefit is payable under this Plan, a Day Care benefit is payable for any Dependent Child under age 13 who was covered by the Plan on the date of the accident. The Child must be enrolled in a Day Care Center on the date of the accident that caused your or your Spouse/Domestic Partner's death, or must be enrolled in a Day Care Center within 90 days after your or your Spouse/Domestic Partner's death.

[2] The Permanent Total Disability benefit is available only to you if you are an Insured Employee. Spouses, Domestic Partners, and Dependent Children are not eligible for a Permanent Total Disability benefit.

The benefit is payable for each year the Dependent Child is enrolled in a Day Care Center. The total amount of the benefit each year is equal to the least of:

- the actual cost of care for the Child charged by the Day Care Center for that year;
- 10% of your or your Spouse/Domestic Partner's Principal Sum on the date of the accident; or
- $10,000.

The Day Care benefit is payable until the earlier of (a) the date when your Child attains age 13, or (b) four years after the later of the date of the accident in which you or your Spouse/Domestic Partner died or the date your Child was enrolled in the Day Care Center. It is not payable for periods prior to the date of the accident that caused the death.

3.4.6 Education.

3.4.6.1 Dependent Child. The Plan provides education benefits to Dependent Child(ren) if:

- You are covered under the Plan; and
- Your accidental death or your insured Spouse/Domestic Partner's accidental death qualifies for Plan benefits.

This Education benefit is payable only on behalf of a Dependent Child who, at the date of the accident, was enrolled as a full-time student at any institution of higher learning beyond the 12th grade level, or is in the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days of the date of the accident.

The total Education benefit for each year is equal to the least of:

1. the actual tuition (*i.e.*, excluding the cost of room and board) charged by such institution during that year for that Dependent Child;
2. 20% of your or your insured Spouse/Domestic Partner's Principal Sum on the date of the accident causing death; or
3. $10,000.

This benefit is payable for a maximum of eight consecutive semester payments, but only if the Dependent Child is continually enrolled as a full-time student in an institution of higher learning. Tuition payments will be made directly to such institution, upon receipt by NUFIC of verification of the student's full-time status and billing for each current semester of enrollment.

3.4.6.2 Spouse/Domestic Partner. If you and your Spouse/Domestic Partner are both covered under the Plan on the date of the accident that causes your death and your accidental death qualifies for Plan benefits, the Plan will pay a benefit to or on behalf of your surviving Spouse/Domestic Partner for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living. To qualify for this benefit, your Spouse/Domestic Partner must either already be enrolled or must enroll within 30 months from the date of your death in any institution of higher learning or professional or trade training program. The benefit will be paid for each year of the insured Spouse/Domestic Partner's continuous enrollment in an institution of higher learning or professional or trade training

program, to a maximum of four consecutive years. The total amount of the benefit for all institutions and programs combined each year is equal to the least of:

1. the actual tuition (i.e., excluding the cost of room and board) charged by those institutions or programs for enrollment during that year for the insured Spouse/Domestic Partner;
2. 20% of your Principal Sum on the date of the accident causing death; or
3. $6,000.

3.4.7 Exclusions. The Plan does not cover, and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at self-inflicted injury;
- Sickness, disease, mental incapacity or bodily infirmity, whether the loss results directly or indirectly from any of these;
- Infections of any kind, regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning, or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition;
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (The unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);
- Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers, or performing, learning to perform, or instructing others to perform as a pilot or crew member in any aircraft, unless this is your Dow job function and in a Company-owned, leased, or operated aircraft or unless you are enrolled in the Recreational Pilot Insurance segment of this Plan (and comply with the terms thereof);
- Declared or undeclared war, or any act of declared or undeclared war, except to the extent provided in the Policy and summarized in Section 3.4.19 of this SPD;
- The Insured Person's commission of or attempt to commit a felony; or
- The Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.

3.4.8 Exposure and Disappearance. If you or your insured Spouse/Domestic Partner or Dependent Child are unavoidably exposed to the elements when in a Covered Accident and this exposure results in a loss for which benefits otherwise are payable, the loss will be covered under this Plan.

If you or your insured Spouse/Domestic Partner or Dependent Child have not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Insured Person was an occupant, the Plan will consider that the Insured Person suffered a loss of life. This provision is subject to all other terms and conditions of the Plan.

3.4.9 Extension of Family Plan Coverage. If a death benefit becomes payable for loss of life of an Insured Employee and at the date of the accident the Insured Employee also insured his/her Spouse/Domestic Partner and/or Dependent Child under the Plan, the Plan will extend coverage for the Spouse/Domestic Partner and/or Dependent Child for an additional twelve months beyond the time coverage would otherwise terminate; provided that the Dependent Child otherwise meets the Plan's eligibility requirements. No premium is charged for this extension of coverage.

3.4.10 In-Hospital. If you or your covered Spouse/Domestic Partner or Dependent Child is hospitalized for more than seven days as a result of a Covered Accident, and such hospitalization occurs within 365 days of that Covered Accident, the Plan will pay a monthly benefit equal to the lesser of $1,000 or one percent of the Principal Sum. Benefits will be paid retroactive to the first day of hospitalization and are payable for up to six consecutive months for any one Hospital confinement. (See definition of "Hospital" in *Appendix A. Definition of Terms*). This benefit is not payable if the Insured Person is confined to a clinic, nursing, convalescent home or a rehabilitation facility for the treatment of alcoholism or substance abuse.

3.4.11 Multiple Losses. If you suffer more than one dismemberment, loss of speech, hearing, or sight, total and permanent disability, paralysis, or coma, from a single accident, you will receive a benefit for only one of the losses. The benefit amount will be for the one loss that provides you the largest percentage of the Principal Sum. This also applies to each covered family member.

3.4.12 Permanent and Total Disability. The Plan pays benefits if you are considered to have a Permanent Total Disability. The Plan does not pay benefits if your Spouse, Domestic Partner, or Dependent Child becomes totally and permanently disabled. Under the Plan, you are considered to have a Permanent Total Disability when as a result of an injury and commencing within 365 days of the date of the accident, you are permanently and totally disabled and you are not able to engage in any occupation or employment for pay or profit for which you are reasonably qualified based on your education, training or experience. Your permanent and total disability must begin within 365 days of the date of the accident and must continue for 12 consecutive months and be total, continuous and permanent at the end of this period.

3.4.13 Recreational Pilot. Enrollment for this benefit is closed. For those who enrolled prior to December 1, 2001, you purchased additional coverage for recreational piloting of a fixed wing aircraft, rotorcraft, balloon, glider and ultra light (where a license is required by law). The recreational pilot coverage amount you selected and the insured family members enrolled prior to December 1, 2001, cannot be changed, except that you may discontinue coverage during the next annual open enrollment period or under the change in status rules. The premium for this coverage remains subject to periodic adjustment as determined by NUFIC. To have been and remain eligible, you must be covered by the Plan and you must be a licensed pilot with either a minimum of 200 flight hours as a pilot with an instrument rating or a minimum of 250 flight hours as a pilot without an instrument rating. Family members insured under this Recreational Pilot coverage must meet the same requirements. The Principal Sum is either $50,000 or $100,000 and cannot be changed.

3.4.14 Rehabilitation Benefit. If you or your covered Spouse/Domestic Partner or Dependent Child suffer an accidental dismemberment or paralysis covered by this Plan, the Plan will reimburse up to $5,000 of Covered Rehabilitative Expenses that are incurred within two years of the Covered Accident. The rehabilitation services must be Medically Necessary as determined by a Physician and the expenses cannot exceed the usual level of charges in

your location. Charges that would not have been made if no insurance existed are not payable. In addition to these exclusions, Covered Rehabilitative Expenses do not include any expenses payable by Workers' Compensation or other similar law.

3.4.15 Repatriation of Remains. If you or your covered Spouse/Domestic Partner or Dependent Child die due to injury in a Covered Accident and the accident occurs while outside a 100 mile radius of your current primary residence, the Plan will pay for covered expenses reasonably incurred to return the decedent's body to the current place of primary residence, up to a maximum of $1,000,000. Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffin or receptacle for transportation of the remains; (3) transportation of the remains by the most direct and economical conveyance and route possible.

3.4.16 Seat Belt and Air Bag. The Plan will pay an amount equivalent to ten percent of the Principal Sum, up to a maximum of $10,000 if a Covered Accident results in your death, the death of your covered Spouse/Domestic Partner, or Dependent Child, while riding in or driving an automobile, and the Insured Person was properly wearing an original factory-installed seat belt or lap and shoulder harness. Automobile means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit. Seat belt benefits shall not be payable if the operator of the vehicle was under the influence of alcohol or drugs, unless prescribed by a licensed physician.

If a Seat Belt benefit is payable, and if the Insured Person was positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, an additional amount is payable. The additional amount is 5% of the principal sum up to a maximum of $5,000. Supplemental Restraint System means an air bag which inflates for added protection of the head and chest areas.

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

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

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

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

3.4.18 Terrorism Scare. The Plan will pay a benefit when the Insured Person suffers one or more losses for which accidental death, dismemberment, coma, or paralysis benefits are payable as a result of a Terrorism Scare (1) that is directed at the Company or its property or assets;

(2) that is not an act of the Insured Person, or an employee of the Company, or a former employee of the Company whose employment ended less than 6 months before the date of the Terrorism Scare; and (3) that occurs while the Insured Person is performing his or her assigned occupational duties for the Company while in or on the premises of the Company. The benefit payable is $500,000. Only one benefit is payable per Insured Person for all losses as a result of the same Terrorism Scare.

3.4.19 War Risk. The Plan covers losses caused by or resulting from declared or undeclared war occurring within the geographic limits or territorial waters of, or airspace above, certain locations in the world covered under the Policy. Currently, this coverage is provided only in Afghanistan, Iraq, and Syria, but you are not covered for losses caused by or resulting from war under the Policy or Plan if any of these is your country of permanent residence. If coverage for war risk terminates prior to the end of a period for which a premium has been paid, any unearned premium will be returned.

3.5 Beneficiary Designations

3.5.1 Employee. Your beneficiary for the Plan is the same as that designated for your Company Paid Life Insurance. If you wish to make a different beneficiary designation for the Plan, you should submit a Voluntary Group Accident Insurance Beneficiary Designation through the Dow Benefits website. If you do not have internet access, HR Solutions can provide assistance. If you do not designate a beneficiary under the Plan or Company Paid Life Insurance, the benefits will be paid in equal shares, to the survivors in the first surviving class of those that follow: your (1) Spouse/Domestic Partner; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is your estate. Please note that this Plan can accept absolute assignments.

3.5.2 Spouse/Domestic Partner. If you elect to insure your Spouse/Domestic Partner under this Plan, you are automatically the beneficiary. If your Spouse/Domestic Partner wishes to designate someone other than yourself, he/she should submit a Voluntary Group Accident Insurance Beneficiary Designation, as above.

3.5.3 Dependent Child. If your Dependent Child is insured under this Plan, you are automatically the beneficiary.

Any beneficiary designation or change to a beneficiary designation will not be recognized if it is received by the Plan Administrator after the Insured Person's death. A beneficiary designation may not be changed by will or other contract (such as a prenuptial agreement), except as permitted under the terms of the Voluntary Group Accident Insurance Beneficiary Designation or to the extent required by a domestic relations order issued by a court that NUFIC determines meets NUFIC's requirements. If your designated beneficiary is a person other than a trustee and the Insured Person and the Insured Person's designated beneficiary die under circumstances in which it is not clear who died first, the designated beneficiary will be deemed to have predeceased you.

If you became an Employee of a Participating Employer as part of the separation of Dow Inc. from DowDuPont Inc., your beneficiary designation was not transferred to the Plan Administrator. If you (or your Spouse/Domestic Partner) wish to name a beneficiary other than the beneficiary described above, you must submit a beneficiary designation as described above.

3.6 Assignment

Subject to the terms of applicable law and the Plan's insurance policy, you may make an assignment, or legal transfer, of the ownership of your coverage under the Plan to any person you choose, or to a trust. Consult your financial advisor for more information. Such assignment must be on file with and made in the form and manner acceptable to the Claims Administrator for Claims for Plan Benefits (NUFIC).

3.7 Filing a Claim. You or your beneficiary must file a written claim in order to apply for a benefit. To initiate a claim, see *Appendix B. Claims Procedures*.

If the Administrator determines that you or your beneficiary is not physically or mentally capable of receiving or acknowledging receipt of benefits under the Plan, the Administrator may make benefit payments to the court-appointed legal guardian of you or your beneficiary, to an individual who has become the legal guardian of you or your beneficiary by operation of state law, or to another individual whom the Administrator determines in its sole discretion is the appropriate person to receive such benefits on behalf of you or the beneficiary.

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

- The amount of any other benefit paid to, or on behalf of, such Participant, Dependent, beneficiary, or other person under the Plan may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant, Dependent, beneficiary, or other person to reimburse the Plan for benefits paid, including reasonable interest.
- If the person does not reimburse the Plan by the date determined by the Plan Administrator, the Plan Administrator may cancel coverage for the Participant and refuse re-enrollment.
- The Plan Administrator may elect recoupment or reimbursement, regardless of whether the person who received the excess benefit was a Participant or beneficiary entitled to receive benefits, and regardless of whether the excess benefit was provided by reason of the Plan Administrator's error or by reason of false, misleading, or inaccurate information furnished by the Participant, beneficiary, or any other person.

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

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

benefit plan, the Plan Administrator may determine that you are not eligible for coverage under the Plan. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. NUFIC may require satisfactory proof of age before paying any claim.

3.10 Your Legal Rights under ERISA.

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts and collective bargaining agreements (if applicable), the Plan Document, and the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. For more information regarding enforcing your rights in court, see Section 3.15 of this SPD regarding litigation and class action lawsuits.

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

about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

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

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

3.13 No Government Guarantee of Welfare Benefits. Welfare benefits, such as the benefits provided by the Plan, are not required to be guaranteed by a government agency.

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

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

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

3.15 Litigation and Class Action Lawsuits

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

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

- in the case of a claim or action to recover benefits allegedly due to you under the terms of the Plan or to clarify your right to future benefits under the terms of the Plan, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Plan first repudiated its alleged obligation to provide such benefits;
- in the case of a claim or action to enforce an alleged right under the Plan (other than a claim or action to recover benefits), the date the Plan first denied your request to exercise such right; or
- in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

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

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

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

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

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

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

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

3.16 Funding. The Plan is funded by an insurance policy underwritten by National Union Fire Insurance Company of Pittsburgh, PA. (NUFIC).

3.17 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 (an "Advisor") to advise them on issues related to the Plan or the Advisee's responsibilities under the Plan:

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

3.18 Waiver

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

3.19 Notices

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

3.20 For More Information

If you have questions, contact HR Solutions at 833-693-6947.

IMPORTANT NOTE

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

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

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

Appendix A. Definition of Terms

Additional terms are defined in the Plan Document.

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

Bargained-for Individual or Bargained-for Employee means an Employee who is represented by a collective bargaining unit that is recognized by the Company or a Participating Employer.

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

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

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

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

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

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

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

Corporate Pilot means an employee who (1) is classified as a pilot by Dow, (2) has a current and valid medical certificate and pilot certificate with appropriate ratings for the aircraft being piloted, and (3) has a minimum of 500 military, private, or professional pilot hours logged, separately or combined.

Covered Accident means an accident that results in a Loss, Injury or Disability described in Section 3.4.1.

Day Care Center means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.

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

Dependent Child(ren) means a child who is principally supported by the Insured Employee and is the Insured Employee's:

- natural child from the moment of birth;
- legally adopted child;
- step-child who permanently resides in the Insured Employee's household;

- foster child; or
- child for whom the Insured Employee or his/her Spouse/Domestic Partner is the legal guardian, who permanently resides in the Insured Employee's household.

Coverage for Dependent Children who meet the above criteria begins on their date of birth or the date of their placement in the home, if later, and continues until the 19th birthday. Dependent Children may continue coverage until their 26th birthday as long as they are full-time students at an accredited institution of higher learning. A child who is physically or mentally incapable of self-support upon attaining 19 years of age may continue coverage under the Plan while remaining incapacitated and unmarried for as long as and you and your Spouse/Domestic Partner are covered by the Plan. Contact HR Solutions at least 31 days before the Child's 19th birthday if this applies to you.

Your child is not eligible if he or she:

- Is employed full-time;
- Is or ever was Married;
- Is serving in the military or similar forces.

Disability Retirement means disability retirement under Rider 4 of the Rohm and Haas Company Retirement Plan (formerly, the Morton International, Inc. Pension Plan for Collectively-Bargained Employees).

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

A. Facts and Circumstances Test

1. The two people live together on the determination date;
2. The two people are not Married to other persons;
3. The two people are each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely;
4. Both people are legally competent and able to enter into a contract;
5. The two people are not related to each other in a way which would prohibit legal Marriage;
6. In entering the relationship with each other, neither of the two people is acting fraudulently or under duress; and
7. The two people have been and are financially interdependent with each other and have submitted proof acceptable to the Plan Administrator of such financial interdependence.

B. Civil Union Test

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

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

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

Employee means a person who:

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

b. receives payment for services performed for the Participating Employer directly from the Company's U.S. payroll or Participating Employer's U.S. payroll;

c. if not a U.S. citizen or resident alien, is Localized in the U.S.; and

d. if on international assignment, is a U.S. citizen or Localized in the U.S.

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

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

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

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

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

If the Plan Administrator or a Participating Employer determines that an individual is not an "Employee," the individual will not be eligible to participate in the Plan, regardless of whether the determination is subsequently upheld by a court or tax or regulatory authority having jurisdiction over such matters or whether the individual is subsequently treated or classified as an Employee for certain specified purposes. Any change to an individual's status by reason of such reclassification or subsequent treatment will apply prospectively only (*i.e.*, will apply to coverage after the reclassification).

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

Flexible Spending Plan means The Dow Chemical Company Flexible Spending Plan, as amended.

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

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

Hospital means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.); and (4) is supervised by one or more Physicians. A Hospital does not include: (a) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (b) a facility that is, other than incidentally, a rest

home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes; or (c) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

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

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

Injury means bodily injury (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person is covered by the Plan, and (2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a loss covered by this Plan.

Insured Employee means an eligible Employee who is properly enrolled in the Plan.

Insured Person means eligible Employees, their Spouse/Domestic Partners and Dependent Child(ren) who are properly enrolled in the Plan.

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

"Localized" occurs when an individual has been determined by 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 person is permanently relocated to the U.S., and such person has accepted such determination.

Limb means entire arm or entire leg.

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

Married or **Marriage** 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 13, 2013, an individual shall be treated as Married only to the extent provided in the provisions of the Plan then in effect.

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

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

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

Permanent Total Disability means that you are totally and permanently disabled and are prevented from engaging in any occupation or employment for compensation or profit for which you are reasonably qualified through education, training or experience. The disability must occur within one year of the date of the accident. Plan benefits for Permanent Total Disability are paid when the disability is continuous for more than 12 consecutive months.

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

Plan means The Dow Chemical Company Voluntary Group Accident Insurance Plan, together with any and all amendments and supplements hereto.

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

Plan Document means the legal instrument under which The Dow Chemical Company Voluntary Group Accident Insurance Plan is operated. The insurance policy through which Plan benefits are funded and this SPD are part of the Plan Document.

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

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

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

Salaried means not represented by a collective bargaining unit.

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

Spouse means a person who is Married to the Employee.

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

Termination of Domestic Partnership occurs when you complete and sign a statement satisfactory to the Plan Administrator that states, among other things, that the Domestic Partnership is terminated. A Termination of Domestic Partnership is not effective with respect to the Plan until the Plan Administrator has received the signed statement.

Terrorism Scare means (1) any report of, or threat to engage in, a terrorist act directly in or on the premises of the Company; or (2) any terrorist act that occurs directly in or on the premises of the Company, whether or not reported or threatened in advance. "Terrorist act" means any violent act that is intended to cause injury, damage or fear and that is committed by or purportedly committed by one or more individuals or one or more members on an organized group in order to (1) make a statement of the individual's or group's political or social beliefs, concepts or attitudes; and/or (2) intimidate a population or government into granting the individual's or group's demands.

Uniplegia means the complete and irreversible paralysis of one Limb.

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

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

Appendix B. Claims Procedures

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

- A *Claim for 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 an Eligibility Determination* for the procedures regarding Claims for Eligibility Determinations.

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

Claims for Plan Benefits

All Claims for Plan Benefits must be filed within 60 days after an Insured Person's loss, or as soon thereafter as reasonably possible.

Claims for an Eligibility Determination

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

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

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

Claims for an Eligibility Determination

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

Claims for Plan Benefits

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

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

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

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

B.4 An Authorized Representative May Act on Your Behalf

An authorized representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Participant. The Plan will recognize a person as a Plan Participant's "Authorized Representative" if such person submits a notarized writing signed by the Participant stating that the Authorized Representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant will also be recognized by the Plan.

B.5 Claims for an Eligibility Determination

B.5.1 Information Required In Order to Be A Claim.

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

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

Claims for an Eligibility Determination must be sent to:

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

B.5.2 Initial Determination.

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

If the Initial Claims Reviewer for Claims for an Eligibility Determination denies the Claim, the written notification of the Claims decision will state the reason(s) why the Claim was denied and refer to the pertinent Plan provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer for Claims for an Eligibility Determination needed additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary. The decision will also describe the appeals procedures (also described below).

B.5.3 Appealing the Initial Determination.

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

- The name of the Employee and the name of the person (Employee, Spouse/Domestic Partner, Dependent Child, as applicable) for whom an eligibility determination is being requested;
- Name of the Plan (The Dow Chemical Company Voluntary Group Accident Insurance Plan, Policy Number PAI-9900841A);
- 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 VGA Plan (Appeal of Eligibility Determination)

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

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

The Appeals Administrator for Claims for an Eligibility Determination will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days after the written request for appellate review, except that under special circumstances, the Appeals Administrator for Claims for an Eligibility Determination may have up to an additional 60

days to provide written notification of the final decision. If the Appeals Administrator for Claims for an Eligibility Determination needs such an extension, s/he will notify you prior to the expiration of the initial 60-day period, state the reason why such an extension is needed, and indicate when s/he will make his or her determination. If an extension is needed because the Appeals Administrator for Claims for an Eligibility Determination determines that s/he does not have sufficient information to make a decision on the Claim, s/he will describe any additional material or information necessary to submit to the Appeals Administrator for Claims for an Eligibility Determination, and provide you with the deadline for submitting such information. The period for deciding your Claim may, in the sole discretion of the Appeals Administrator for Claims for an Eligibility Determination, be tolled until the date you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator for Claims for an Eligibility Determination may decide the Claim without the additional information.

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

B.6 Claims for Plan Benefits

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

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

B.6.1 Notification of Accident. Within 60 days, or as soon thereafter as possible, notify HR Solutions of the accident, along with a brief description of the circumstances, the type of injury, the date and location of the accident, and the names of the Employee, Spouse/Domestic Partner and/or Dependent Child involved. Your supervisor, business partner, family member, or beneficiary may provide this notification on your behalf.

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

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

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

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

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

- Certified copy of the death certificate
- Copy of the police report and, if applicable, internal accident report and autopsy report
- Copy of newspaper or other articles related to the accident
- If the death was a result of injuries sustained in an automobile accident, written statement from a police officer, fire fighter, paramedic, ambulance personnel, or fellow passenger indicating whether or not a seat belt was worn by the Insured Person at the time the accident occurred, and whether the Supplemental Restraint System inflated properly upon impact. If this information is included in the police report, an additional statement is not necessary.
- Copy of the beneficiary designation
- If the Beneficiary is a minor child, include a certified copy of the Court appointment naming the guardian of the minor child's estate
- If there is no beneficiary designation, the full name and address of the Insured Person's Spouse/Domestic Partner
- If there is no Spouse/Domestic Partner, the full name, address, and birth date of each child. A certified copy of the Court appointment naming the guardian of the minor children's estate is needed as well
- If there is no child, the full name and address of the Insured Person's parents
- If there are no parents, the full names and addresses of the Insured Person's brothers and sisters
- If there are no brothers and sisters, a certified copy of the Court appointment naming the Administrator or Executor of the participant's estate

Send the completed claim to:

VGA Claims Processor
The Dow Chemical Company
North America Benefits
P. O. Box 2169
Midland, MI 48641-2169

The VGA Claims Processor will forward your Claim to:

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

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

- Copy of the police report and, if applicable, internal accident report
- Copy of newspaper or other articles related to the accident

Send the completed claim to:

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

The VGA Claims Processor will forward your Claim to:

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

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

- Job Description
- Educational background
- Work history, including jobs performed with any prior employers
- Copy of the police report and internal accident report if applicable
- Copy of newspaper or other articles related to the accident
- Depending on the regulations in your location and the nature of the Permanent Total Disability *(e.g.,* coma), it may be necessary to provide a certified copy of a court order appointing a guardian for the Insured Employee.

Send the completed claim to:

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

The VGA Claims Processor will forward your Claim to:

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

B.6.6 Legal Actions. No action at law or in equity may be brought to recover on this Plan prior to the expiration of the Applicable Limitations Period described in Section 3.15 of this SPD.

B.7 Initial Decision on a Claim for Plan Benefits

NUFIC is the Initial Claims Reviewer for Claims for Plan Benefits and will review your Claim and notify you of its decision to approve or deny your Claim. Claims for Plan Benefits involving a

determination of disability will be decided in accordance with Section B.7.2, and all other Claims for Benefits will be decided in accordance with Section B.7.1.

B.7.1 Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims. The Initial Claims Reviewer for Claims for Plan Benefits will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer for Claims for Plan Benefits may have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer for Claims for Plan Benefits needs such an extension, it will notify you prior to the expiration of the initial 90-day period, state the reason why such an extension is needed, and state when it will make its determination.

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

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

Such notification will be provided to you within a reasonable period, not to exceed 45 days after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer for Claims for Plan Benefits may have up to two (2) additional extensions of 30 days each (totaling 60 days) to provide you such notification. If the Initial Claims Reviewer for Claims for Plan Benefits needs such extensions, it will notify you prior to the expiration of the initial 45-day period (or the first 30-day extension period if a second 30-day extension period is needed), state the reason why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete Claim, the period for deciding your Claim may, in the sole discretion of the Initial Claims Reviewer for Claims for Plan Benefits, be tolled from the date on which the notification of extension is sent to you until the date on which you respond to the request for additional information. If you do not provide the additional information within 45 days, the Initial Claims Reviewer for Claims for Plan Benefits will decide the Claim without the additional information.

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

- The specific reason or reasons for the denial of the Claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
- An explanation of the Plan's appeal procedures and the applicable time limits;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan

Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your Claim, without regard to whether the advice was relied upon in denying your Claim; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits);

- If the denial of your Claim was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Initial Claims Reviewer for Claims for Plan Benefits under applicable federal regulations; and
- A statement of your right to bring a civil action under section 502(a) of ERISA, if your Claim is denied upon review.

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

NUFIC is the Appeals Administrator for Claims for Plan Benefits and will review your appeal and notify you of its final decision. Claims for Plan Benefits involving a determination of disability will be decided in accordance with Section B.8.2, and all other Claims for Benefits will be decided in accordance with Section B.8.1.

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

- Employee name;
- Employee number;
- Dependent or beneficiary name if the Dependent or beneficiary is the person who is appealing the Initial Claims Reviewer's decision;
- Name of the plan (The Dow Chemical Company Voluntary Group Accident Insurance Plan, Policy Number PAI-9900841A);
- Reference to the Initial Determination; and
- An explanation of the reason why you are appealing the Initial Determination.

Send the appeal to:

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

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

After the Appeals Administrator for Claims for Plan Benefits receives your written request to appeal the initial determination, the Appeals Administrator for Claims for Plan Benefits will review your Claim. Deference will *not* be given to the initial adverse decision, and the Appeals Administrator for Claims for Plan Benefits will look at the Claim anew. The Appeals Administrator for Claims for Plan Benefits will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days of the written request for appellate review, except that under special circumstances, the Appeals Administrator may have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator for Claims for Plan Benefits needs such an extension, it will notify you prior to the expiration of the initial 60-day period, state the reason why such an extension is needed, and state when it will make its determination.

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

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

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

B.8.2 Permanent Total Disability Benefit Claims. If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. You must file a written appeal within 180 days of receipt of the notice of denial from the Initial Claims

Reviewer for Claims for Plan Benefits, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator for Claims for Plan Benefits, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

- the name of the Employee;
- the name of Dependent or beneficiary, if the Dependent or beneficiary is the person who is appealing the Initial Claims Reviewer's decision;
- the name of the plan (The Dow Chemical Company Voluntary Group Accident Insurance Plan, Policy Number PAI-9900841A);
- reference to the Initial Determination; and
- an explanation of the reason why you are appealing the Initial Determination.

Send the appeal to:

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

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

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

- Deference will *not* be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The person who will review your appeal will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim.
- The Appeals Administrator for Claims for Plan Benefits will take into account all comments, documents, records, and other information submitted to the Appeals Administrator for Claims for Plan Benefits that is related to the Claim without regard to whether such information was submitted or considered in the initial determination.
- If the initial determination was based on medical judgment, the Appeals Administrator for Claims for Plan Benefits will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person consulted in connection with the initial determination, and will not be a subordinate who reports to the person who was consulted in connection with the initial determination.
- The Appeals Administrator for Claims for Plan Benefits will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in

connection with the initial decision, without regard to whether the advice was relied upon in making the initial decision.

- In addition, for Claims for Plan Benefits arising after April 1, 2018, the Appeals Administrator for Claims for Plan Benefits will provide you with the following information, free of charge, as soon as possible and in advance of the deadline for notifying you of the Appeals Administrator for Claims for Plan Benefits' decision:
    - Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit decision in connection with the Claim; and
    - Any new or additional rationale for issuing an adverse benefit decision on appeal.

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

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

- The specific reason or reasons why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Appeals Administrator for Claims for Plan Benefits under applicable federal regulations;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about the voluntary appeal procedures;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your appeal, without regard to whether the advice was relied upon in denying your appeal; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits);

- If the denial of your Claim on appeal was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and
- A statement of your right to bring a civil action under section 502(a) of ERISA and any deadline for filing a lawsuit, including the calendar date of the deadline to file a lawsuit for your Claim.

Appendix C. Named Fiduciaries as of October 1, 2019

The Named Fiduciaries are designated by the Plan Sponsor in accordance with the Plan Document. This Appendix C includes the Named Fiduciaries as of October 1, 2019. However, the Named Fiduciaries may be changed from time to time. For inquiries about the persons or entities currently serving as Named Fiduciaries, call 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	Kim Gora	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Tammie Hunt	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Associate HR Specialist	Emily Small	October 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Associate HR Specialist	Matthew Salim	October 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	Benefits Plan Manager	Holly Gerisch	January 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	North America Benefits Leader	Ryan Marra	January 1, 2019
Plan Administrator	Global Benefits Director	Bryan Jendretzke	January 1, 2019
Plan Administrator	Benefits Plan Manager	Holly Gerisch	January 1, 2019