THE DOW CHEMICAL COMPANY
GROUP LIFE INSURANCE PROGRAM

UNION CARBIDE SUBSIDIARY BASIC LIFE INSURANCE PLAN
SUMMARY PLAN DESCRIPTION

(FOR CERTAIN UCC RETIREES)

Effective January 1, 2019, and thereafter until superseded

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

Copies of updated SPDs (including this SPD) are available at the Dow Benefits & Well-being website (www.dowbenefits.com) or by requesting a copy from the Dow Retiree Service Center (800-344-0661) or by submitting your request through the Dow Benefits website's Message Center (http://dowbenefits.ehr.com).

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

TABLE OF CONTENTS

Section 1. Overview

This is the Summary Plan Description ("SPD") for the Union Carbide Subsidiary Basic Life Insurance Plan ("Plan"), offered under The Dow Chemical Company Group Life Insurance Program (the "Program").

The Plan is sponsored and administered by The Dow Chemical Company (the "Company") and provides group term life insurance underwritten by Metropolitan Life Insurance Company ("MetLife"). Different eligibility and coverage levels apply depending on your Annual Pay and whether you are a retired Salaried Employee or a retired Hourly Employee.

The Plan became available effective January 1, 2002, to Retirees of Union Carbide Corporation and certain of its subsidiaries ("Union Carbide") who retired before February 7, 2003. The Plan replaced the Union Carbide Basic Life Insurance Plan ("Pre-merger UCC Plan"), which was sponsored by Union Carbide Corporation before its merger with the Company. The Pre-merger UCC Plan was terminated effective December 31, 2001.

In general, the Plan provides the following benefits:

- Early Retiree Optional Life Insurance for certain eligible Retirees under age 65;
- Retiree Life Insurance for certain eligible Retirees age 65 and older and eligible Retirees under age 65 who do not elect Early Retiree Optional Life Insurance; and
- certain disability benefits.

The Retiree must pay a premium for Early Retiree Optional Life Insurance. Currently, UCC pays the premium for Retiree Life Insurance. MetLife pays the benefits under the Plan and is the named fiduciary for making decisions as to whether a Claim for Plan Benefits is payable.

The Plan is governed by the plan document for the Program, which is the legal instrument under which the Program is operated. This legal instrument is referred to in the SPD as the "Plan Document." If there is any inconsistency between this SPD and the Plan Document, the Plan Document shall govern.

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. You may request a copy of the Plan Document from the Plan Administrator.

The Dow Chemical Company reserves the right to amend, modify or terminate the Plan (and the Program of which the Plan is a part) 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 for the Program, or in the *Guide to Terms Used Here*, immediately below. 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 2. Guide to Terms Used Here

Additional terms are defined in the Plan Document.

Annual Pay: Your annualized base rate of pay as of the earlier of the date immediately preceding retirement, the date you reach age 65, Total Disability, or Total and Permanent Disability. Where applicable, shift differential is included.

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

Basic Life Insurance: Two times (2X) your Annual Pay. The maximum amount of coverage may not exceed $1.5 million.

Beneficiary: The person(s) you name to receive your life insurance benefit if you die. If no Beneficiary survives you or if the Beneficiary cannot be located, the benefit will be paid to your estate.

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

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

Claim for Plan Benefits: A Claim requesting that the Plan pay for benefits covered under the Plan.

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

Code: The Internal Revenue Code of 1986, as amended.

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

Early Retiree: A Retiree who is less than age 65.

Early Retiree Optional Life Insurance: The same as the Basic Life Insurance; or two times (2X) your Annual Pay. You and the Company share in the cost to purchase this coverage. The maximum amount of coverage may not exceed $1.5 million.

Employee: A person who:

- Is employed by Union Carbide to perform personal services in an employer-employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute;
- Receives a payment for services performed for Union Carbide or the Company directly from Union Carbide's or the Company's U.S. Payroll Department;

- Does not receive compensation for services performed for the benefit of Union Carbide or the Company from an entity that is not Union Carbide or the Company; and

- Is classified by Union Carbide as having "regular employee" status, or by the Company as having "regular full-time" or "less than full time" status.

The definition of "Employee" does not include an individual who is determined by the Plan Administrator or Union Carbide or the Company 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 Union Carbide pursuant to an agreement between Union Carbide and another business, such as a leasing organization;

2. An individual retained by Union Carbide or the Company 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 UCC or the Company 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: Employee Retirement Income Security Act of 1974, as amended.

Hourly Employee: An Employee who has been classified by the Company as an "Hourly Employee."

Initial Claims Reviewer: With respect to deciding Claims for Plan Benefits, MetLife. The Initial Claims Reviewer with respect to deciding a 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 Initial Claims Reviewer for Claims for an Eligibility Determination is listed in *Appendix B. Named Fiduciaries*.

MetLife: Metropolitan Life Insurance Company.

Participant: A Retiree who is both eligible to participate in the Plan and is enrolled in the Plan.

Plan: The Union Carbide Subsidiary Basic Life Insurance Plan (For Certain UCC Retirees).

Plan Administrator: 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 B. Named Fiduciaries*.

Plan Document: The legal instrument under which the Program is operated. The insurance policy through which Plan benefits are funded, the insurance certificates, and the summary plan descriptions for the plans offered under the Program, including this SPD, are part of the Plan Document.

Plan Year: The 12-month period beginning each January 1 and ending each December 31.

Pre-merger UCC Plan: The Union Carbide Corporation Basic Life Insurance Plan sponsored by UCC prior to its merger with the Company and which was terminated effective December 31, 2001.

Program: The Dow Chemical Company Group Life Insurance Program (ERISA Plan #507), of which the Plan is a component plan.

Regular Employee: An Employee who is classified by the Company as "regular."

Retiree: An Employee who has terminated from Union Carbide (and is not employed by a successor employer or divested or joint venture business) and who is eligible at the time of termination, due to meeting age and service requirements, to immediately commence his or her pension under the Union Carbide Employees' Pension Plan and continue participation in UCC's life insurance and medical plans.

Retiree Life Insurance: Life insurance coverage provided to eligible Retirees. The amount varies depending on the year in which you retired, your Annual Pay, and whether you were a Salaried Employee or an Hourly Employee.

Salaried Employee: An Employee who has been classified by the Company as a "Salaried Employee."

SPD (Summary Plan Description): The summary plan description for the Plan. The SPD is a part of the Plan Document.

Total Disability: As a result of bodily injury or disease, you are prevented from engaging in any and every business or occupation and from performing any work for compensation or profit for which your education, background and training qualify you. This definition is used to determine whether your life insurance contributions will be suspended.

Total and Permanent Disability: You have terminated employment because you have become totally and permanently disabled as a result of bodily injury or disease so as to be wholly prevented from engaging in any occupation or employment for wage or profits, and there is no foreseeable chance of recovery. This definition is used to determine when life insurance will be paid as disability income.

UCC: Union Carbide Corporation.

Union Carbide: Union Carbide Corporation and certain of its subsidiaries and former subsidiaries that are authorized to participate in this Plan.

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

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

Section 3. Eligibility

You became eligible for coverage under the Plan if:

- You are a Retiree who retired before January 1, 2002, and were enrolled in the Pre-merger UCC Plan for at least five years immediately before retirement;

- You were a Regular Employee of Union Carbide who retired on or after January 1, 2002, and before February 7, 2003, and--

    - Were enrolled in life insurance coverage under The Dow Chemical Company Employee-Paid Life Insurance Plan equal to at least 1X (one times salary); and

    - Had at least 5 years of total coverage under the Union Carbide Basic Life Insurance Plan and The Dow Chemical Company Employee-Paid Life Insurance Plan; or

- You were a Regular Employee of Union Carbide who was enrolled in the Pre-merger UCC Plan for at least one year immediately before December 31, 2001, and before January l, 2002, was "Totally Disabled" or "Permanently and Totally Disabled".

In addition, a limited amount of coverage ($625) is available for Retirees who retired before February 7, 2003, and who had, immediately before retirement, one or more years but less than five years participation in total under the Pre-merger UCC Plan and/or The Dow Chemical Company Employee-Paid Life Insurance Plan.

If you were a Regular Employee of Union Carbide who is receiving benefit payments from The Dow Chemical Company Long Term Disability Income Protection Plan ("LTD") and is also receiving benefit payments from the Union Carbide Employees' Pension Plan, you continue to be eligible for life insurance coverage under the Plan, subject to the following rules:

- UCC will pay the Retiree's portion of the premium (if any) until the Retiree is no longer eligible to receive LTD payments.

- None of the Total Disability or Totally and Permanently Disabled provisions of the Plan (such as those described in Sections 9 or 10) apply.

Employees and Retirees who participate in, or once participated in, the Union Carbide Executive Life Insurance Plan, are not eligible.

The Claims Administrator for Claims for an Eligibility Determination determines eligibility. The Claims Administrator is a Plan fiduciary and has the full discretion to interpret provisions of the SPD and Plan Document 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 the *Appendix A. Claims Procedures*.

Section 4. Early Retiree Optional Life Insurance

ELIGIBILITY FOR EARLY RETIREE OPTIONAL LIFE INSURANCE

If you retire at age 65 or older, you are not eligible for Early Retiree Optional Life Insurance; you may be eligible for Retiree Life Insurance (see *Retiree Life Insurance*, below). If you meet the eligibility requirements for the Plan and you retired before age 65, you had the following options at your retirement:

- You could have elected Retiree Life Insurance (see *Retiree Life Insurance*, below), for which UCC currently pays the entire premium. You cannot subsequently change to the Early Retiree Optional Life Insurance once you have elected the Retiree Life Insurance; or

- You could have elected Early Retiree Optional Life Insurance (2X your Annual Pay, determined at the time of your retirement or Total and Permanent Disability) if--

    - You retired before January 1, 2002, with five or more years of participation in the Pre-merger UCC Plan; or

    - You retired on or after January 1, 2002, and before February 7, 2003, and you (1) were enrolled for at least 1X Employee-Paid Life Insurance coverage under The Dow Chemical Company Employee-Paid Life Insurance Plan on the day immediately preceding your retirement, and (2) had at least 5 years of coverage in total under the Pre-merger UCC Plan and The Dow Chemical Company Employee-Paid Life Insurance Plan.

If you elected Early Retiree Optional Life Insurance at retirement, UCC currently pays for coverage up to 40% of your Annual Pay. You pay for the balance of coverage.

At age 65, your Early Retiree Optional Life Insurance was or will be reduced automatically to the Retiree Life Insurance. You can change from Early Retiree Optional Life Insurance to Retiree Life Insurance earlier than age 65 if you choose, by calling the Dow Retiree Service Center at 800-344-0661. Once you change to Retiree Life Insurance, you may not subsequently change back to Early Retiree Optional Life Insurance.

Example (Assuming the Employee Retires on or after January 1, 2002)

Assume that an Employee retires at age 62 on or after January 1, 2002, and before February 7, 2003, and meets the eligibility requirements described above. If the Employee's Annual Pay (determined as of immediately prior to retirement) is $30,000, he or she could either:

- Elect Retiree Life Insurance equal to $12,000 of coverage (see *Retiree Life Insurance*, below, for how this amount of coverage is calculated), for which UCC currently pays the entire premium; or

- Elect Early Retiree Optional Life Insurance coverage equal to 2X Annual Pay (or $60,000), for which UCC currently pays the premium for coverage up to 40% of the Employee's Annual Pay or ($12,000).

PREMIUMS FOR EARLY RETIREE OPTIONAL LIFE INSURANCE

The Early Retiree Optional Life Insurance coverage amount is 2 times (2X) your Annual Pay (determined at the time of your retirement or Total and Permanent Disability). UCC currently pays the premiums for

coverage equal to 40% of your Annual Pay, and you must pay the premiums for the balance. Premium rate changes may occur in the month you reach the respective age for which a rate change is applicable. Refer to Dow Family Health or contact the Dow Retiree Service Center for premium information. ***Premiums are subject to change at any time.***

Section 5. Retiree Life Insurance

You must have had at least five years of participation in either, or a combination of, the Pre-merger UCC Plan or The Dow Chemical Company Employee-Paid Life Insurance Plan immediately before retirement in order to be eligible for Retiree Life Insurance coverage. The amount of Retiree Life Insurance available to a Retiree is shown in the table below. UCC currently pays the premiums for Retiree Life Insurance.

	Retiree Life Insurance coverage under the Plan (expressed as your "Death Benefit")
If you retired before January 1, 1973:	OPTION 1 Your last salary multiplied by 2 Multiplied by 1% Times years of service Plus $500 Equals your Death Benefit, up to a maximum of $10,000
If you retired on or after January 1, 1973, but before February 7, 2003, and--	
• Your last annual salary was $25,000 or less:	Death Benefit equal to the greater of— OPTION 1 (see the formula above) *or* OPTION 2: Your last salary multiplied by 2 Multiplied by 25% Equals your Death Benefit, up to a maximum of $10,000
• You were a Salaried Employee and your last annual salary was greater than $25,000:	Your last salary multiplied by 2 Multiplied by 20% Equals your Death Benefit
You were an Hourly Employee and your last annual salary was greater than $25,000	Your last salary multiplied by 2 Multiplied by 20% Equals your Death Benefit, up to a maximum of--
• You retired on or after January l, 1973 and before January 1, 1990:	$10,000
• You retired on or after January 1, 1990 and before January 1, 1995:	$15,000
• You retired on or after January 1, 1995 and before January l, 1998:	$18,000
• You retired on or after January 1, 1998 and before February 7, 2003:	$20,000

Section 6. Annual Pay is Rounded Up

Your life insurance coverage, under either the Early Retiree Optional Life Insurance or the Retiree Life Insurance, is calculated using your Annual Pay, rounded up to the next thousand dollars.

Example of How Your Benefit Is Calculated:	
Salaried Employee	Annual Pay: $30,200
	Annual Pay rounded up to next thousand: $31,000
	Early Retiree Optional Life Insurance amount: $62,000 (2 times $31,000)
Hourly Employee	Hourly rate at retirement: $14 per hour
	Hours worked per week: 40 hours
	Number of weeks per year: 52 weeks
	Annual Pay: $29,120 (14 times 40 times 52)
	Annual Pay rounded to next thousand: $30,000
	Early Retiree Optional Life Insurance amount: $60,000 (2 times $30,000)

Section 7. How Benefits Are Paid

If you are covered under the Plan, your Plan life insurance coverage pays a death benefit regardless of the cause of your death. There are no exclusions.

In the event of your death, your beneficiary should contact the Dow Retiree Service Center at (800) 344-0661. The beneficiary on record must complete and sign a claim form to receive benefits. A death certificate that states the cause of death must be provided to MetLife in order to disburse the life insurance proceeds. A copy of the certified death certificate is allowed, unless otherwise requested. See *Appendix A. Claims Procedures*. If the benefit is less than $5,000, it will be paid in full by check. If the benefit is $5,000 or more, it will be paid using a Total Control Account ("TCA"), as described below, unless your beneficiary requests payment by check. Contact the Dow Retiree Service Center at (800) 344-0661 with any questions.

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

Total Control Account

If the death benefit payable to your beneficiary is $5,000 or more, the claim will automatically be paid using a "draft account" called the "Total Control Account" ("TCA"), unless your beneficiary requests payment by check. The TCA is an alternative to paying the benefits to your beneficiary in full by check. The TCA is an interest-bearing account that MetLife establishes to provide your beneficiary with immediate access to the entire amount of the benefit. MetLife pays interest on the balance in the TCA from the date the TCA is established until the amount is withdrawn. The TCA provides a guaranteed minimum interest rate, specified at the time the draft account is created. Your beneficiary can withdraw all or part of the TCA balance at any time without charge or penalty, simply by writing drafts subject to a minimum withdrawal amount, currently $250. Your beneficiary may withdraw the entire balance immediately or at any time. The holder of the Total Control Account will receive statements showing the account balance, draft payees, and interest earned.

The TCA is not a bank account and not a checking, savings, or money market account.

Note: MetLife may receive investment earnings from operating the TCA that are greater than the amount of interest that MetLife pays to your beneficiary on the balance in the TCA. The performance results of any investments that MetLife makes with the TCA do not affect the interest rate MetLife pays to your beneficiary.

Section 8. Accelerated Benefits Option

Under the Accelerated Benefit Option ("ABO"), if you have been diagnosed as terminally ill with 12 months or less to live[1], you may be eligible to receive a portion of your Plan coverage amount before your death if certain requirements are met. Having access to life proceeds at this important time could help ease financial and emotional burdens. In order to apply for the ABO, you must be covered for at least $10,000 of coverage under the Plan. You may receive an accelerated benefit of up to 80 percent (maximum of $500,000) of your Plan coverage amount. The accelerated benefit is payable by check. You can elect the accelerated benefit only once for each eligible coverage. Any death benefit will be reduced by the amount of any accelerated benefit paid. After MetLife pays the accelerated benefit, any future contributions you are required to pay for Life Insurance will be waived. Accelerated benefits are not permitted if you have assigned your life insurance benefit to another individual or to a trust.

The ABO is intended to qualify for favorable tax treatment under the Internal Revenue Code such that the benefits will be excludable from your U.S. federal income and not subject to U.S. federal taxation. Payment of the accelerated benefit may be subject to state tax laws and restrictions. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor, and neither the Plan nor Union Carbide or the Company makes any assertion or warranty about the tax treatment of Plan benefits.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse/domestic partner or your family, for public assistance programs such as medical assistance (Medicaid), Aid to Families and Dependent Children ("AFDC"), Supplemental Security Income ("SSI"), and drug assistance programs. You are advised to consult with social services agencies concerning the effect receipt of accelerated benefits may have on public assistance eligibility for you, your spouse/domestic partner, or your family.

[1] For Texas residents, the requirement is 24 months or less to live.

In the event your life insurance coverage ends or is reduced in the future, the amount of coverage you may be eligible to convert or port will be reduced by the amount of the accelerated benefit received.

If you would like to apply for the Accelerated Benefit Option, a claim form can be obtained from the Dow Retiree Service Center at 800-344-0661 and must be completed and returned for evaluation and approval by MetLife.

Section 9. If You Became Totally Disabled Before Jan. 1, 2002: Contributions Suspended

If you became Totally Disabled before January 1, 2002, you may be (or may have been) eligible to receive Basic Life Insurance at no cost to you as described in the Plan documents in effect on January 1, 2002. In general, Basic Life Insurance ends on the earlier of the date you are no longer Totally Disabled or the date you reach age 65. The Plan documents in effect on January 1, 2002, also set forth the rules for maintaining Basic Life Insurance during periods of Total Disability, including the requirements for providing proof of continued disability.

If you are (or were) eligible for Retiree Life Insurance at the time that your Basic Life Insurance ends (or ended), you may receive that coverage as described in the Retiree Life Insurance section (see *Retiree Life Insurance*, above).

Section 10. If You Became Totally and Permanently Disabled Before Jan. 1, 2002: Disability Income Paid from Basic Life Insurance

If you became Totally and Permanently Disabled before January 1, 2002, you may be (or may have been) eligible to receive Basic Life Insurance at no cost to you and monthly disability income under the Plan (up to 60 monthly installments of the first $20,000 of Basic Life Insurance) as described in the Plan document in effect on January 1, 2002. In general, Basic Life Insurance ends on the earlier of the date you are no longer Totally and Permanently Disabled or the date you reach age 65.

If you are (or were) eligible for Retiree Life Insurance at the time that your Basic Life Insurance ends (or ended), you may receive that coverage as described in the Retiree Life Insurance section (see *Retiree Life Insurance*, above). Your Retiree Life Insurance, if any, will be (or was) reduced to take into account any amount already paid in monthly disability income under the Plan.

> ***Example:*** An Employee is Totally and Permanently Disabled and his or her last Annual Pay before Total and Permanent Disability was $60,000. Before reaching age 65, the Employee has Basic Life Insurance Coverage of 2X Annual Pay or $120,000. He or she receives $20,000 of Basic Life Insurance payments over 60 months while he or she is disabled. If he or she dies before reaching age 65, the death benefit would equal $100,000 ($120,000 - $20,000 that was already paid to him or her).
>
> The Employee's Basic Life Insurance coverage ends when he or she reaches age 65. He or she is eligible for Retiree Life Insurance when his or her Basic Life Insurance ends. His or her Retiree Life Insurance is 40% of his or her last salary, which is reduced by any basic life insurance amounts already paid as disability income using the following formula: Annual Pay at time of Total and Permanent Disability minus (total amount of monthly installments divided by 2). Accordingly, his or her Retiree Life Insurance is $20,000.

Annual Pay reduced by amounts received in disability income = $60,000 - ($20,000/2) = $50,000

Retiree Life Insurance = 40% X $50,000 = $20,000

Section 11.
Filing a Claim and Appealing a Denial of a Claim

See *Appendix A. Claims Procedures*.

Section 12. Fraud Against the Plan

If you intentionally misrepresent information to the Plan, knowingly withhold relevant information from the Plan, or deceive or mislead the Plan, the Plan Administrator may (1) terminate your participation in the Plan 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, the Plan and/or Dow may 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 Program.

Section 13. U.S. Federal Tax Consequences of Coverage and Benefits

The following information is a brief summary of the complex tax rules that may be relevant as a result of your participation in the Plan. Before enrolling in the Plan or selecting a Beneficiary, you should consult a professional tax advisor for guidance. Neither the Plan, nor the Company nor Union Carbide makes any assertion or warranty about the tax treatment of Plan coverage or benefits. The Participant or Beneficiary, as applicable, shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

INCOME TAX ON DISABILITY BENEFITS

A portion of the annual benefits received as a result of total and permanent disability is taxable. The taxable portion will be reported on IRS Form 1099 mailed to you by MetLife after the end of the year.

INCOME TAX ON IMPUTED INCOME

Current Internal Revenue Code rules permit the Company's cost for the first $50,000 of Plan coverage to be excluded from your U.S. federal taxable income, if any. The Internal Revenue Code requires that the cost of coverage paid by the Company in excess of $50,000 be reported as U.S. federal taxable income ("imputed income"). This imputed income will be reported to the IRS in addition to your annual pension income information. The imputed income is determined based on a Uniform Premium Table established by the U.S. federal government.

If the cost of coverage paid by the Company exceeds $50,000, and you want to decrease the amount of the coverage to $50,000, you may elect to do so by contacting the Dow Retiree Service Center. Once coverage is reduced, it may not be reinstated.

You are advised to consult with a qualified tax advisor. Neither the Plan nor the Company nor Union Carbide makes any assertion or warranty about the tax treatment of Plan benefits.

Section 14. Porting Coverage to a Separate Group Term Life Policy

If your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage under the Plan ends or is reduced because:

- You cease to be in a class that is eligible for this coverage; or
- Your coverage is reduced because of age; or
- the Company cancels the MetLife group life insurance policy or amends the Plan to exclude or change the amount of coverage for your group; then

the amount of coverage you lost may be continued on a direct bill basis with MetLife through the portability feature. Portability allows Retirees to continue all or part of their group term life coverage under a separate group policy without completing and submitting a statement of health. Although not required, completing and submitting a statement of health may help reduce your cost. Rates for this coverage are different from the retiree plan rates, and you must port a minimum of $10,000 to exercise this option.

The maximum amount you may port is $2,000,000. However, if your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage under the Plan ends because the Company has cancelled the coverage under the MetLife group life insurance policy or because the Company has amended the Plan to exclude coverage for your group, the maximum amount you may port is limited to the lesser of:

- the amount of your Retiree Life Insurance or Early Retiree Optional Life Insurance that ends under the MetLife group policy, less the amount of life insurance for which you become eligible under any group policy issued to replace the MetLife group policy; or
- $10,000.

You have 31 days from the date your coverage ends or is reduced to apply for portability. You may continue the same or a lesser amount of coverage (subject to the limits described above). If you do not continue your entire life insurance amount through portability, you may apply for conversion of the balance, as described immediately below.

You are responsible for initiating this process within the appropriate time frame. For your convenience, MetLife will send the appropriate forms for review. MetLife has an exclusive arrangement with financial professionals from Massachusetts Mutual Life Insurance Company (MassMutual) to offer you advice on the options available to you. You may receive a call from a local, specially trained MassMutual financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor Union Carbide makes any assertion or warranty about the qualifications of or advice provided by financial professionals.

If you do not receive the forms or an outreach call within approximately two weeks after your coverage has decreased or terminated, contact the Dow Retiree Service Center at 1-800-344-0661 for further assistance.

Section 15.Converting to an Individual Non-Term Life Policy

If your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage ends because you no longer meet the eligibility requirements of the Plan, your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage may be converted to an individual non-term policy through MetLife. The maximum amount of insurance that may be elected for the new policy is the amount of coverage in effect for you under the Plan on the date you no longer meet the eligibility requirements of the Plan.

If your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage ends because the Company terminates the coverage under the MetLife group life insurance policy, or the Company has amended the Plan to exclude coverage for your eligible group, you may convert your Retiree Life Insurance coverage or Early Retiree Optional Life Insurance coverage to an individual non-term MetLife policy; provided you have been covered under the Plan for at least 5 years immediately prior to losing coverage under the Plan. The amount you may convert is limited to the lesser of:

- the amount of life insurance for you that ends under the Group Policy less the amount of life insurance for which you become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or

- $10,000.

You must file a conversion application with MetLife and make the required premium payment to MetLife within 31 days of the date your Plan coverage is lost or reduced. You are responsible for initiating the conversion process within the appropriate timeframes. For your convenience, MetLife will send the appropriate forms for review. MetLife has an exclusive arrangement with financial professionals from Massachusetts Mutual Life Insurance Company (MassMutual) to offer you advice on the options available to you. You may receive a call from a local, specially trained MassMutual financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor Union Carbide makes any assertion or warranty about the qualifications of or advice provided by financial professionals.

If you do not receive the forms or an outreach call within approximately two weeks after your coverage has decreased or terminated, contact the Dow Retiree Service Center at 1-800-344-0661 for further assistance.

The cost of this individual coverage will probably be significantly higher than your group plan. Although not required, completing and submitting a statement of health may help reduce your cost.

If you die within 31 days after your life insurance ends or is reduced by an amount you are entitled to convert, your beneficiary should contact the Retiree Service Center, complete and sign a claim form, and provide proof of death to MetLife (see *Appendix A. Claims Procedures*). MetLife will review the claim and, if the claim is approved, will pay your beneficiary the amount you were entitled to convert. The amount you were entitled to convert will not be paid as insurance under both a new individual conversion policy and the group policy.

Section 16. Naming Your Beneficiary

You must designate a Beneficiary by registering your Beneficiary information with MetLife at http://mybenefits.metlife.com, or by mailing the appropriate beneficiary forms to the MetLife Recordkeeping Center.

You should submit the appropriate form to MetLife even if you submitted one to Dow before June 1, 2008.

If you do not submit a Beneficiary designation to MetLife in the form and manner required by MetLife while you are living, MetLife may determine your Beneficiary to be any one or more of the following who survive you:

- Your Spouse or Domestic Partner;
- Your child(ren);
- Your parent(s);
- Your sibling(s).

Alternatively, instead of making payment to any of the above, MetLife may pay your estate. Your failure to designate a Beneficiary may delay the payment of funds. Any payment made by MetLife in good faith will discharge the Plan's and MetLife's liability to the extent of such payment.

If you wish to change your beneficiary designation, you can do so through the MetLife website (http://mybenefits.metlife.com), through the Dow Benefits & Well-being website (www.dowbenefits.com), or through the Dow Benefits Enrollment Website (http://dowbenefits.ehr.com). If you prefer, you can request forms by calling MetLife Customer Service toll-free at (866) 492-6983, Monday through Friday, 8:00 am to 11:00 pm (ET). A life event (such as marriage/domestic partnership, divorce/termination of domestic partnership, etc.) may signal a need to change your Beneficiary, but a life event will not automatically change your Beneficiary.

Any beneficiary designation or change to a beneficiary designation will not be recognized if it is delivered to MetLife after your 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 beneficiary designation or to the extent required by a domestic relations order issued by a court that MetLife determines meets MetLife's requirements. If your Beneficiary is a person other than a trustee and you and your Beneficiary die under circumstances in which it is not clear who died first, the Beneficiary will be deemed to have predeceased you.

Section 17. 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, 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, Beneficiary, or other person under the Plan may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant, 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 Retiree or his or her estate.

Section 18. Assignment

You may make an assignment, or legal transfer, of the ownership of your Basic Life Insurance, Early Retiree Optional Life Insurance or Retiree Life Insurance to any person you choose, or to a trust. Consult your financial advisor for more information. Such assignment must be made in the form and manner acceptable to the Plan Administrator.

Section 19. Grief Counseling and Legal & Financial Consultation

Grief Counseling

Your Basic Life and Retiree Life Insurance coverage come with Grief Counseling[2] at no extra cost, provided by LifeWorks US, Inc. ("LifeWorks"). Grief Counseling is a specific form of therapy aimed at helping people cope with grief and mourning associated with the death of a loved one, or with major life changes that trigger feelings of grief. This service is available to you, your dependents and your beneficiaries to discuss any situation you perceive as a major loss, including:

- Death of a loved one
- Divorce
- Receiving a serious medical diagnosis
- Losing your job

You, your dependents and your beneficiaries can have up to five confidential counseling sessions per event. Sessions can either take place in person or by phone. If further assistance is desired, the counselor will help you access services that are appropriate to your situation, preferences, finances and health insurance coverage.

To access this service, call 1-888-319-7819 (a dedicated 24/7 toll-free number) to speak with a licensed professional counselor experienced in helping people who have suffered a loss. You can also log on to http://metlife.lifeworks.com (username: metlifeassest; password: support) to contact a counselor or access helpful grief-related information and resources.

[2] Subject to state regulatory approval. Grief Counseling services are provided through an agreement with LifeWorks. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of 30,000 counselors. Counselors have masters or doctoral degrees and are licensed professionals with extensive experience working with people who have suffered a loss.

Additional assistance from research specialists is also available at the same toll-free number at no cost. These specialists can refer services and providers as well as offer additional information that you may find helpful. They can help you:

- Locate local funeral homes and cemetery options;
- Locate back-up care for children or older adults;
- Find local support groups;
- Find funeral cost estimates from local providers; and
- Locate services providers such as florists, caterers, and hotels.

They can also provide information on important tasks such as notifying the Social Security Administration, banks and utilities.

Legal and Financial Consultation

Your Basic Life and Retiree Life Insurance coverage comes with legal and financial consultation at no extra cost, provided by LifeWorks. You have access to:

- A LifeWorks' in-house attorney for a 30-minute consultation to assist you on making informed decisions as it pertains to a loss.
- 1 hour consultation with a certified financial planner to assist with education, strategies, and options.

The legal and financial consultation services are not part of the Plan. Neither the Plan, the Company, nor Union Carbide makes any assertion or warranty about the qualifications of or advice provided by legal or financial professionals.

Section 20. Funeral Planning and Discounts[3]

With your Retiree Life Insurance coverage, you are eligible to receive discounts of up to 10% off the service provider's standard price for certain funeral services including funeral, cremation, and cemetery products and services provided by Dignity Memorial, a third party national network of funeral and funeral planning providers. You also have access to funeral planning resources including funeral planning tools and concierge services provided by Dignity Memorial.

MetLife has arranged for these services and discounts to be provided to you, your Spouse/Domestic Partner, your children, your parents, your grandparents, and your great-grandparents at no extra cost.

Access to counselors and discounts on funeral services through Dignity Memorial. Visit the financial planning and discounts website *(*www.finalwishesplanning.com*)* or call 866-853-0954.

The funeral discount and planning services are not part of the Plan.

[3] Subject to state regulatory approval. Not available in all jurisdictions.

Section 21.Your Legal Rights under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), the Plan Document and the latest annual reports filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements (if applicable), and copies of the latest annual report, the Plan Document, and an 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 Plans, called "fiduciaries" of the Plans, have a duty to act prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer or any other person, may discharge you, or otherwise discriminate against you in any way, for pursuing a welfare benefit or for exercising your rights under ERISA. If you have a Claim for Plan Benefits that is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

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

Section 22. 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 B. 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 and capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan Document for the Program and the *Appendix A. Claims Procedures*.

Section 23. Plan Document

The Plan will be administered in accordance with its terms. If the VPHR determines that the Plan Document has a drafting error (sometimes called a "scrivener's error''), the Plan Document 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.

Section 24. Funding

This Plan is funded by an insurance policy underwritten by MetLife. Currently, UCC pays the premiums for Retiree Life Insurance and Basic Life Insurance, and Retirees and UCC share the premiums for Early Retiree Optional Life Insurance. MetLife pays the benefits under the insurance policy.

Section 25. 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.

Section 26. Company's Right to Terminate or Amend the Plan

The Company reserves the right to amend, modify, or terminate any or all of the Program and the Plan (including amending the Plan Document and the SPDs) 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 Program and 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.

Section 27. Litigation and Class Action Lawsuits

LITIGATION

If you wish to file a lawsuit against the Program (a) to recover benefits you believe are due to you under the terms of the Program or any law; (b) to clarify your right to future benefits under the Program; (c) to enforce your rights under the Program; or (d) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you may not file a lawsuit until you have exhausted the claims procedures described in the *Appendix A. Claims Procedures*, below 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. (A lawsuit against the Plan is considered a lawsuit against the Program of which the Plan is a part, for purposes of this SPD.)

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

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the Program or to clarify your right to future benefits under the terms of the Program, 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 Program first repudiated its alleged obligation to provide such benefits;

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

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

If a lawsuit is filed on behalf of more than on 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 for Plan Benefits, as described in the *Appendix A. Claims Procedures*, below, 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 60 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.

CLASS ACTION LAWSUITS

Legal actions against the Program must be filed in U.S. federal court. Class action lawsuits must be filed in either (1) the jurisdiction in which the Program 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 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 Program, all parties to such action that are related to the Program (such as a Program 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.

Section 28. Privilege

If the Company or Union Carbide (or a person or entity acting on behalf of the Company or a Union Carbide) 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 Retiree, 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 Retiree, 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.

Section 29. 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.

Section 30. 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.

Section 31. For More Information

If you have questions about Plan benefits or enrollment, contact the Dow Retiree Service Center at (800) 344-0661.

IMPORTANT NOTE

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Group Life Insurance Program's Union Carbide Subsidiary Basic Life Insurance 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 Plan Document, the Plan Document will govern.

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

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

Section 32. ERISA Information

The Dow Chemical Company Group Life Insurance Program's
Union Carbide Subsidiary Basic Life Insurance Plan

Type of Plan	Life insurance
Type of Plan Administration	Insurer administration
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 (800) 344-0661
Employer Identification Number	38-1285128
MetLife Insurance Policy Number	11700-G
Plan Number	507
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 B. 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 Union Carbide Subsidiary Basic Life Insurance Plan (800) 344-0661

	The Grief Counseling services benefit is administered by LifeWorks.
To Serve Legal Process	General Counsel The Dow Chemical Company c/o HR Legal Department Global Dow Center 2211 H.H. Dow Way Midland, MI 48674 For disputes arising under those portions of the Plan administered by LifeWorks, service of legal process may be made upon LifeWorks.
Claims Administrators for Claims 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 B. Named Fiduciaries*. The address and phone number for the Claims Administrator 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 Union Carbide Subsidiary Basic Life Insurance Plan (Eligibility Determination) *Appeals Administrator* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Appeals Administrator for the Union Carbide Subsidiary Basic Life Insurance Plan (Eligibility Determination)
Claims Administrator for Claims for Plan Benefits	Metropolitan Life Insurance Company administers claims under a group policy issued to The Dow Chemical Company: Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505
Claims Information for Grief Counseling	Contact LifeWorks at (888) 319-7819 to obtain eligibility and benefit claims information for the Grief Counseling services.
Plan Year	The Plan's fiscal records are kept on a Plan Year beginning January 1 and ending December 31.

Funding	This Plan is funded by an insurance policy underwritten by MetLife. Currently, UCC pays the premiums for Retiree Life Insurance and Basic Life Insurance, and Retirees and UCC share the premiums for Early Retiree Optional Life Insurance. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees, and other administrative expenses) may be paid by the Company, Union Carbide, or from the assets of the Plan, if any. Grief Counseling services are provided through an agreement between MetLife and LifeWorks. The services LifeWorks provides are separate and apart from the insurance policy underwritten by MetLife. No contribution is required for Grief Counseling services.

Appendix A.
Claims Procedures

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

> A *Claim for Plan Benefits* is a request for benefits covered under the Plan.
>
> A *Claim for an Eligibility Determination* is a request for a determination as to whether a claimant is eligible to be a Participant under 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 Life Insurance Benefits*, *Claims for Disability Benefits*, or *Claims for an Eligibility Determination*, whichever applies to your situation. See applicable sections below.

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 these 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:* 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 B. Named Fiduciaries*.
>
> *Claims for a Plan Benefit:* The Initial Claims Reviewer and the Appeals Administrator are MetLife.

AUTHORITY OF THE ADMINISTRATORS AND YOUR RIGHTS UNDER ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Plan Document and to make findings of fact in order to carry out their respective decision-making responsibilities. However, the Claims Administrators' determinations are subject to the interpretations of the Plan Document made by the Plan Administrator. Interpretations and Claims decisions by the Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). You may file a civil action against the Plan under section 502 of the Employee Retirement Income Security Act (ERISA) in a federal court, provided you complete the claims procedures described in this Appendix (or the Claims Administrator fails to timely respond to your Claim). If the Claims Administrators' determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. Please see *Litigation and Class Action Lawsuits* for the deadline for filing a lawsuit.

AN AUTHORIZED REPRESENTATIVE MAY ACT ON YOUR BEHALF

An Authorized Representative may submit a Claim or request certain documents relating to the Plan from the Plan Administrator on behalf of a Plan 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.

HOW TO FILE A CLAIM FOR AN ELIGIBILITY DETERMINATION

For Claims for an Eligibility Determination, the Claim must be in writing and contain the following information:

- The name of the Retiree (or other former employee) for whom the eligibility determination is being requested.

- The name of the Plan for which the eligibility determination is being requested *(i.e.,* the Union Carbide Subsidiary Basic Life Insurance Plan).

Claims for an Eligibility Determination must be filed with:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Initial Claims Reviewer for the Union Carbide Subsidiary Basic Life Insurance Plan (Eligibility Determination)

HOW TO FILE A CLAIM FOR LIFE INSURANCE BENEFITS

For Claims for Plan Benefits involving life insurance benefits, the claimant must call the Dow Retiree Service Center at (800) 344-0661 to report the death. The Company will contact MetLife on your behalf and you will receive the appropriate Claimant Statement forms and instructions directly from MetLife. In addition, a death certificate that states the cause of death is required. A copy of the certified death certificate is allowed, unless otherwise requested. If you need help completing the MetLife Claimant Statement, you may request assistance from MetLife Group Claims at (800) 638-6420, during the hours of 8:00 AM-5:00 PM Monday through Friday.

Once you have completed the MetLife Claimant Statement, you must send it along with the certified death certificate to:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

Or, the claimant may complete and submit the Claim electronically. Submitting the Claim electronically will expedite the process; allow the beneficiary to upload requested supporting documentation, such as a death certificate or power of attorney; and enable the beneficiary to track the status of the Claim online. If the Claim is submitted electronically, a copy of the certified death certificate is acceptable.

Initial Determinations

If you submit a Claim for Plan Benefits, you must do so as soon as reasonably possible, but no later than twelve months, after the date of death. If you submit a Claim for an Eligibility Determination, you must

do so before the end of the year in which you seek enrollment or for which you claim that you were charged an incorrect premium. The Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days after the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer may have up to an additional 90 days to provide you such written notification. If the Initial Claims Reviewer needs such an extension, it will notify you prior to the expiration of the initial 90 day period, state the reason why such an extension is needed, and state when it will make its determination.

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

Appealing the Initial Determination

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

- the name of Retiree or former Employee;
- the name of the beneficiary, if the beneficiary is the person appealing the Claims Administrator's decision;
- the name of the Plan *(i.e.,* the Union Carbide Subsidiary Basic Life Insurance Plan)'
- reference to the initial determination; and
- an explanation of the reason why you are appealing the initial determination.

Appeals of Claims for an Eligibility Determination should be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for the Union Carbide Subsidiary Basic Life Insurance Plan (Appeal of an Eligibility Determination)

Appeals of Claims for Plan Benefits should be sent to:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
Attention: Claims Administrator for the life insurance plans of The Dow Chemical Company and certain of its subsidiaries (Appellate Review)

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

After the Appeals Administrator receives your written request to appeal the initial determination, the Appeals Administrator will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The Appeals Administrator 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 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 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, and provide you with the deadline for submitting such information.

The period for deciding your Claim may, in the Appeals Administrator's sole discretion, be tolled until the date you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator 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 under applicable federal regulations); and (4) that you have a right to bring a civil action under section 502 of ERISA.

HOW TO FILE A CLAIM FOR DISABILITY BENEFITS

If you want to file a Claim for Plan Benefits involving disability benefits, you must complete a MetLife Claim form and provide documentation showing that you were Totally Disabled and/or Permanently and Totally Disabled during, and for the time required under the Plan. Contact the Retiree Service Center at:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641-2169
Attention: Plan Administrator for the Union Carbide Subsidiary Basic Life Insurance Plan
(800) 344-0661

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

MetLife Disability
P.O. Box 14590

Lexington, KY 40511-4590
Attention: Union Carbide Basic Life Insurance Disability

Initial Determination for Disability Claims

When you submit a Claim for Plan Benefits involving disability benefits to the Initial Claims Reviewer for Claims for Plan Benefits, the Initial Claims Reviewer for Claims for Plan Benefits will review your Claim and notify you of its decision to approve or deny your Claim. Any decision to retroactively cancel your coverage under the Plan (for a reason other than the failure to pay premiums) will be treated as a decision by the Initial Claims Reviewer to deny a Claim for Plan Benefits.

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

For Claims Filed on or before April 1, 2018

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

1. The specific reason or reasons for denial of the Claim;

2. References to the specific Plan provisions upon which such denial is based;

3. An explanation of the Plan's appeal procedures and the applicable time limits;

4. A description of any the additional material or information necessary to perfect the Claim, and an explanation of why such information is necessary;

5. If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request;

6. If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request; and

7. A statement of your right to bring a civil action under section 502(a) of ERISA if your Claim is denied upon review.

For Claims Filed after April 1, 2018

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

1. The specific reason or reasons for denial of the Claim;

2. References to the specific Plan provisions upon which such denial is based;

3. A description of any additional material or information necessary to perfect the Claim, and an explanation of why such information is necessary;

4. An explanation of the Plan's appeal procedures and the applicable time limits;

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

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

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

8. A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Initial Claims Reviewer for Claims for Plan Benefits under applicable federal regulations; and

9. A statement of your right to bring a civil action under section 502(a) of ERISA if your Claim is denied upon review.

Appealing the Initial Determination for Disability Claims

If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim for disability benefits, you may appeal the decision. In addition, if you were being paid benefits and you have been notified that these benefits will be terminated, you may also appeal the decision to terminate your benefits. You must file a written appeal within 180 days of receipt of the notice of denial from the Initial Claims Reviewer' for Claims for Plan Benefits, assuming that there are not extenuating circumstances, as determined by

Appeal Administrator for Claims for Plan Benefits, in which case the time to file the appeal may be more than 180 days. Your written appeal must be in writing and must include the following information:

- the name of the Retiree or former Employee;
- the name of the Plan *(i.e.*, the Union Carbide Subsidiary Basic Life Insurance Plan);
- reference to the initial determination; and
- an explanation of the reason why you are appealing the initial determination.

Send your appeal to:

Claims Administrator
MetLife Disability
P.O. Box 14592
Lexington, KY 40511-4592
Attention: Claims Administrator for Union Carbide Basic Life Insurance Plan - Disability Claim (Appellate Review)

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

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

- Deference will *not* be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The person who will review your appeal will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim.
- The Appeals Administrator will take into account all comments, documents, records, and other information submitted to the Appeals Administrator for Claims for Plan Benefits that is related to the Claim without regard to whether such information was submitted or considered in the initial determination.
- If the initial determination was based on medical judgment, the Appeals Administrator for Claims for Plan Benefits will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person consulted in connection with the initial determination, and will not be a subordinate who reports to the person who was consulted in connection with the initial determination.
- The Appeals Administrator for Claims for Plan Benefits will identify any medical or vocational experts whose advice was obtained on behalf the Plan in connection with the initial decision, without regard to whether the advice was relied upon in making the initial decision.
- In addition, for Claims for Plan Benefits arising after April 1, 2018, the Appeals Administrator for Claims for Plan Benefits will provide you with the following information, free of charge, as soon as

possible and in advance of the deadline for notifying you of the Appeals Administrator for Claims for Plan Benefits' decision:

- Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit decision in connection with the Claim; and

- Any new or additional rationale for issuing an adverse benefit decision on appeal.

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

For All Appeals Filed after April 1, 2018

If the Appeals Administrator for Claims for Plan Benefits denies the Claim on appeal, the Appeals Administrator for Claims for Plan Benefits will send you a final written decision that includes:

1. The specific reason or reasons why the Claim you appealed is being denied;

2. References to the specific Plan provisions on which the denial is based;

3. A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Appeals Administrator for Claims for Plan Benefits under applicable federal regulation;

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

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

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

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

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

Appendix B.
Named Fiduciaries as of October 1, 2019

The Named Fiduciaries are designated by the Plan Sponsor in accordance with the Plan Document. This Appendix B 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