Summary Plan Description for:

Union Carbide Corporation, a subsidiary of The Dow Chemical Company

Long Term Disability Plan

ERISA Plan #545

Effective January 1, 2019 and thereafter until superseded

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

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

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

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Overview

This is the Summary Plan Description ("SPD") for the Union Carbide Corporation Long Term Disability Plan (the "Plan"). This plan is a group disability income protection plan. All benefits provided under the plan are insured through an insurance policy underwritten by Metropolitan Life Insurance Company ("MetLife").

This Plan is available to former employees of Union Carbide Corporation and certain of its subsidiaries (collectively referred to as "UCC" or "Union Carbide") who were already receiving benefit payments or were eligible to receive benefit payments (if offsets are greater or equal to the Target Disability Income) from this Plan prior to January 1, 2002. In addition the Plan is available to UCC employees who became totally disabled **prior to** January 1, 2002 who meet the eligibility requirements of this Plan. Employees of UCC who were actively at work on or after January 1, 2002 are not eligible for this Plan.

The Plan is designed to protect participants and their families in the event of a lengthy disability. If an eligible participant becomes totally disabled for the required period of time, he or she may receive up to the Target Disability Income from the Plan, depending on offsets from other sources, such as social security, life insurance, and payments from the Union Carbide Retirement Program. While being paid LTD benefits, you earn company service credit under the Union Carbide Retirement Program if you have at least 5 years of service when you became totally disabled.

The Plan is governed by the plan document for the Plan, which is the legal instrument under which the Plan is operated. This legal instrument is referred to in this SPD as the "Plan Document."

This SPD is a summary of the MetLife Certificate of Insurance and the Plan Document. If there is any inconsistency between this SPD, the Certificate of Insurance, or the Plan Document, the Certificate of Insurance shall govern. If there is an inconsistency between the SPD and the Plan Document, the Plan Document shall govern.

This SPD contains important information about the benefits under the Plan. However, it does not contain all of the information. Further information can be found in the Plan Document for the plan. The Plan Document is available upon request from the Plan Administrator identified in the *ERISA Information* section of this SPD.

Union Carbide Corporation reserves the right to amend, modify and terminate the Plan at any time in its sole discretion.

The SPD and the Plan do not constitute a contract of employment. Capitalized words in this SPD are defined either in the Plan Document or in *Definition of Terms*, 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.

Definition of Terms

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

Active Work: An individual must be regularly working, and physically and mentally able to perform the normal duties of one's occupation.

Annual Pay: Annualized base rate of pay plus shift differential, if applicable.

Appeals Administrator: With respect to reviewing an adverse Claim for Plan Benefits, the Appeals Administrator is 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*.

Appropriate Care & Treatment: Medical care and treatment that meet all of the following:

1. It is received from a doctor whose medical training and clinical experience are suitable for treating your disability;
2. It is necessary to meet your basic health needs and is of demonstrable medical value;
3. It is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research, health care coverage organizations, and government agencies;
4. It is consistent with the diagnosis of your condition; and
5. Its purpose is maximizing your medical improvement.

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

Claim for an Eligibility Determination: A Claim requesting 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.

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 of the sentence in which the term is used.

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

Company Service Credit: Company Service Credit has the same meaning as defined in the Union Carbide Retirement Program.

Covered Pay: Your annual pay, plus other compensation such as profit sharing (if applicable) or eligible awards you received from the Corporation during the 12 months before LTD payments started. These other sources of compensation may have come from Union Carbide's Profit Sharing Plan, Variable Compensation Plans, the UMETCO Mineral Corporation Variable Compensation Plan and The Dow Chemical Company Performance Award Program.

Note: If the average payment received from the other sources named above during the past 36 months is greater than the amount received during the past 12 months, the average payment will be used. However, by law, the covered pay that may be considered under the plan is limited to $200,000. This amount is subject to change each year by the Internal Revenue Service.

Credited Service: Credited Service has the same meaning as defined in the Union Carbide Retirement Program.

Disability (Union Carbide Retirement Program definition): This definition applies to the Union Carbide Retirement Program. It is here for convenience because the term is referred to in this summary plan description. This term does not describe the requirements necessary to meet the Plan's definition of "totally disabled". Under the Union Carbide Employees' Pension Plan (formerly known as the Retirement Program Plan for Employees of Union Carbide Corporation and its Participating Subsidiary Companies), "disability" means that you have terminated employment due to your total physical or mental inability, resulting from bodily injury or disease, to perform any work for compensation or profit in any occupation for which you are reasonably qualified by reason of training, education or ability, and which is adjudged to be permanent and continuous during the remainder of your life as determined by the plan administrator of the Union Carbide Retirement Program on the basis of evidence satisfactory to it. "Disability" does not include any bodily injury or disease incurred or suffered as a result of an addiction to narcotic drugs, an intentionally self-inflicted injury, or engaging in a criminal (whether misdemeanor or felonious) act.

Employee: 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 a payment for services performed for a Participating Employer directly from a Participating Employer's or The Dow Chemical Company's U.S. Payroll Department; and

c. Does not receive compensation for services performed for the benefit of a Participating Employer from an entity that is not a Participating Employer or The Dow Chemical Company.

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

Initial Claims Reviewer: With respect to deciding Claims for a Plan Benefit, the Initial Claims Reviewer is MetLife. The initial claims reviewer with respect to deciding Claims for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance

with the Plan Document. The person, group of persons, or entity designated as the Initial Claims Reviewer for Claims for an Eligibility Determination is listed in *Appendix B. Named Fiduciaries*.

Long Term Disability: You have been totally disabled for at least 6 months and remain totally disabled and under the continuous and appropriate care and treatment of a physician in order to maximize your medical improvement.

Long Term Disability Benefit: Income from the Plan that is paid if your income from other sources of disability benefits is less than the Target Disability Income.

MetLife: Metropolitan Life Insurance Company. MetLife is a Claims Administrator and a Named Fiduciary of the Plan.

Participant: Each Employee or such other individual who, in accordance with the Plan, is eligible to participate in the Plan, elects to participate in the Plan, and remains eligible for benefits under the Plan.

Participating Employer: The Company or one of its subsidiaries that has been authorized by the Company to participate in the Program. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the 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.

Plan: The Union Carbide Corporation Long Term Disability Plan.

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 plan document for the Plan, which is ERISA Plan #545. The Summary Plan Description is an integral part of the Plan Document.

Plan Sponsor: Union Carbide Corporation.

Plan Year: The 12-consecutive-month period ending each December 31.

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

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

Target Disability Income: Target Disability Income means 60% of covered pay up to a maximum of $10,000/month if your qualifying disability was incurred prior to January 1, 1995. Target Disability Income means 65% of covered pay up to a maximum of $8,125/month if your qualifying disability was incurred on or after January 1, 1995. Under the Plan your total monthly disability income from all sources will not be less than the Target Disability Income amount.

Totally Disabled (Plan definition):

- For the first 24 months of disability, "totally disabled" means that you are unable to perform the duties of your own occupation or other appropriate work assigned by Union Carbide because of illness or accidental injury. Your own occupation means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with Union Carbide. It may be a similar activity that could be performed with Union Carbide or any other employer.
- After the first 24 months of disability, "totally disabled" means that you are unable to perform the duties of any occupation, which is not limited to the specific position you held with UCC, for

which you are qualified by reason of your training, education or experience sufficiently to earn at least the Target Disability Income.

UCC: Union Carbide Corporation.

Union Carbide Retirement Program: Union Carbide Employees' Pension Plan (formerly known as the Retirement Program Plan for Employees of Union Carbide Corporation and its Participating Subsidiary Companies). The provisions of the Union Carbide Retirement Program that apply to participants in this Plan appear in Appendix A of the plan document for the Union Carbide Retirement Program.

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

Eligibility

You are eligible for coverage under this Plan if you are a former Regular Employee who was already receiving benefit payments or were eligible to receive benefit payments (if offsets are greater or equal to Target Disability Income) from this Plan prior to January 1, 2002.

You are also eligible for coverage under this Plan if you are a Regular Employee of a Participating Employer who:

- Was on the UCC payroll on December 31, 2001, and
- Became totally disabled while employed by a Participating Employer **prior to** January 1, 2002, and
- Were enrolled in Union Carbide's Basic Life Insurance Plan on December 31, 2001, and
- Were enrolled in the Plan during the 2001 Plan Year, and
- Were enrolled in the Plan on the date you became totally disabled.

Except as described in the 6 Month Waiting Period section of this SPD, if you are an Employee of a Participating Employer who was actively at work on or after January 1, 2002, you are not eligible for this Plan.

If you have been approved for disability payments under The Dow Chemical Company Long Term Disability Income Protection Plan, you are not eligible to participate in the Plan.

If you want to file a Claim for an Eligibility Determination, see *Appendix A. Claims Procedures*.

Enrollment

There are no new enrollments in this Plan. You must have been enrolled in the 2001 Plan Year or you must already have been receiving payments or have been eligible to receive benefit payments (if offsets are greater or equal to Target Disability Income) under the Plan prior to January 1, 2002 in order to be eligible to participate in this Plan.

Benefits

Calculating Your LTD Benefit

- Calculate your Target Disability Income
- Add up your other sources of disability benefits
- Do the other sources equal the target?
- If not, LTD makes up the difference

Target Disability Income

This is the amount the Plan would pay if you had no other sources of disability benefits. For example, if your Target Disability Income is 65%, and your covered pay is $40,000 per year:

	Maximum Benefit Available
Employee's covered pay	$40,000 Per Year
	x .65
Target disability income	$26,000 Per Year ($2,167 Per Month)

Other Sources of Disability Benefits

The other sources of disability benefits that help you reach your target disability income are:

- Basic Life Insurance – You may be eligible for a total and permanent disability benefit for the first 5 years of disability. (See the Union Carbide Retiree Basic Life Insurance summary plan description.)
- Union Carbide Retirement Program – You may be eligible for a disability benefit or you may be eligible for a pension benefit at normal retirement age
- Social Security – You may be eligible for disability benefits (individual or family) from the U.S. or another country
- Worker's Compensation due to loss of time
- Any other disability and retirement benefits required by statute

Even if you fail to apply for the "other sources of disability benefits" listed above, they will count as other sources of disability benefits if MetLife determines that you are eligible for them.

These other sources of disability benefits, when combined, may be more or less than the Target Disability Income. If they are less, the Plan steps in with a benefit to make up the difference. However, if they are equal to or more than the Target Disability Income, no LTD benefit will be paid under this Plan.

An increase in Social Security benefits while you are disabled will not affect your LTD benefit. Also, any other personal insurance that pays you benefits as a result of total disability will have no impact on your LTD benefit (except you cannot receive LTD benefits from this Plan and also receive LTD benefits from The Dow Chemical Company Long Term Disability Income Protection Plan). These payments will be added income for you.

Is Plan membership of value if your LTD benefit works out to be little or none? To answer this question, be aware that if you were not enrolled in the Plan, you would not earn Company Service Credit under the Union Carbide Retirement Program while Totally Disabled. This Company Service Credit counts in figuring the amount of your normal retirement benefit. You may earn up to 30 years of such service while disabled and eligible for a LTD benefit. See *LTD and Retirement Program Work Together* for

more information. Please note that you must have 5 years of company service credit under the Union Carbide Retirement Program on your last day of work to be eligible to accrue service while receiving LTD payments.

Determining LTD Benefits - Example

Employee's Target Disability Income:	$18,000 per year
In Year 1, Employee's Other Sources of Disability Benefits:	
Basic Life Insurance	$4,320
Disability Pension	$5,000
Estimated Primary Social Security benefit	+ $9,500
Total Disability Income	$18,820
Remaining Benefit from LTD	**$0**

In this example, the employee's other sources of disability benefits are greater than the target disability income of $18,000. No benefits are paid from the Plan. At the end of 5 years, however, the employee's total and permanent disability benefit from basic life insurance ends, leaving the employee with less than the target disability income of $18,000. The Plan makes up the difference:

Total Disability Income	$18,820 per year
Basic Life Insurance	- 4,320 per year
Remaining Other Source of Disability Benefits	$14,500 per year
Target Disability Income	$18,000 per year
Employee's Other Source of Disability Income	- 14,500 per year
LTD Benefit	**$3,500 per year**

Payment of LTD Benefits

When Payments Start

To qualify for LTD payments, your total disability must have continued for at least 6 consecutive months except as described in the section below entitled, "6 Month Waiting Period", and you must no longer be receiving benefits from any UCC salary continuation plans, such as the Non-Occupational and Occupational Disability Pay Plan, or the Salary Continuation Plan.

LTD payments are made by MetLife on a monthly basis.

6-Month Waiting Period

The 6-month waiting period is for 6 consecutive months, except as described here. If during the 6-month waiting period you recover sufficiently from your disability so that you can return to work, but then the same illness or injury causes you to again not be able to work, the question of whether you must begin the 6-month waiting period anew arises. The answer depends on how long you were able to return to work. If the 6-month waiting period is interrupted for a total of 90 or more days, during which days you returned to work for partial or full day(s), then if you must be off work again because of the same disability, the 6-month waiting period must begin anew. If the 6-month waiting period is interrupted for a total of less than 90 days, during which days you returned to work for partial or full day(s), then the 6-month waiting period does not need to begin anew, and any time off because of the disability will count toward the 6-month waiting period.

Duration of Benefits

LTD benefits continue for up to 24 months while you remain Totally Disabled from your own occupation and under the continuous and appropriate care and treatment of a medical doctor in order to maximize your medical improvement. After that, if you are unable to perform the duties of any occupation for which you are qualified by reasons of training, education, or experience and prior economic status and are confined in a legally certified hospital and/or under the care of a medical doctor for treatment of said conditions, LTD continues until the occurrence of any of the following, at which time LTD benefits end:

- The end of the month in which you reach age 65
- The date you fail to attend a medical examination as requested by the plan administrator
- The date you cease to be disabled
- The date of your death

Tax Treatment of Coverage and Benefits

Fifty percent of the LTD benefit that you receive is taxable. MetLife does not withhold taxes from your benefit on a mandatory basis. However, you may request withholding by completing the form W-4S included in your claim package. MetLife will mail you a Form W-2 each year that will report the amount of your taxable LTD benefit and the amount of taxes withheld, if any.

Since tax laws change, you should consult a professional tax advisor for further information. Neither the Company, nor any other Participating Employer or any other affiliate, makes any assertion or warranty about whether any taxes are required by any government or government agency to be withheld from, or paid with respect to, amounts paid under the Plan. The Participant shall bear all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

Successive Disabilities

If you qualify for LTD benefits (whether or not they were actually paid), return to active work for less than 90 days, and again become disabled from the same illness or injury, the 6-month waiting period will not be required in order to requalify for benefits. See *6-Month Waiting Period*.

Vocational Rehabilitation

Ordinarily, LTD benefits stop if you are able to return to work. However, if MetLife determines that you are able to enroll in an approved program of vocational rehabilitation, your LTD benefits will continue for up to 24 months. They will be reduced by 50% of any pay earned from vocational rehabilitation.

Pre-existing Conditions

Employees who waited more than 90 days to enroll in the Plan were subject to the Plan's pre-existing condition exclusion. This exclusion applied for the first 12 months of Plan membership. The Plan does not pay benefits during that time for any disability for which the employee was treated during the three months immediately before enrolling in the Plan.

Exclusions

The Plan will not pay benefits for disabilities which result from:

- An act of war (declared or undeclared), riot, or insurrection,
- Self-inflicted injury while sane or insane,
- Injuries sustained while in the commission of a felony, or
- Medical care received from an unlicensed physician.

LTD and Retirement Program Work Together

While you are disabled, you may be eligible for a disability pension from the Union Carbide Retirement Program. See the summary plan description for the Union Carbide Retirement Program for information about disability benefits available under the Union Carbide Retirement Program. The following information is a summary of the disability benefits available under the Union Carbide Retirement Program, and is here for convenience only. If there is any conflict between this SPD and the Union Carbide Retirement Program plan document, the Union Carbide Retirement Program plan document shall prevail.

Filing for a Disability Pension

To qualify for a disability pension under the Union Carbide Retirement Program, you must be Disabled at the time of disability.

If you have at least 10 years of Credited Service when you become disabled, you may file immediately for a disability pension from the Union Carbide Retirement Program.

If you have at least 8 but less than 10 years of Credited Service when you become disabled, the Union Carbide Retirement Program allows you to accrue the additional years of Credited Service needed to qualify for a disability pension while you are receiving LTD benefits. Your disability pension will begin after you have received LTD payments for up to 2 years, provided you continue to be Disabled. It will be based on 10 years of Company Service Credit. Your LTD benefit will be reduced by the amount of your disability pension.

Normal Retirement at Age 65

At age 65, your disability pension will cease and you will begin receiving a normal retirement pension. Your normal retirement pension will be based on all of your Company Service Credit, including years of Company Service Credit earned while receiving a LTD benefit.

Earning Company Service Credit – While you are receiving LTD payments, you will continue to earn Company Service Credit toward a normal retirement pension if you have at least 5 years of Company Service Credit when you become disabled. This additional service credit will increase the amount of your normal retirement pension. It will not increase the amount of your disability pension or qualify you for early retirement. The service accrual stops:

- if you cease to be disabled,
- if you decline to provide medical evidence of your continuing disability as required by the Claims Administrator, or
- when you have accrued up to 30 years of additional company service credit.

Note: If you are denied a disability pension, but are approved for an LTD benefit and are vested under the terms of the Union Carbide Retirement Program, you will also accrue years of service for the purposes of the Retirement Program as specified in that program.

How the Plan and UCC Retirement Program Work Together

An employee, age 30, has 8 years of Credited Service at the time LTD payments are approved. The following Plan/Retirement Program events may occur:

Employee's Age	Plan/Retirement Program Event
30	Plan benefits start, with no reduction for disability pension
32	Eligibility for disability pension starts, based on 10 years of Credited Service and the determination that you satisfy the disability requirements under the Union Carbide Retirement Program. Plan benefit is reduced by the amount of the disability pension.
60	Employee concludes 30 years of maximum Company Service Credit accrued under the Union Carbide Retirement Program
65	Disability pension ceases, normal retirement pension starts, based on 38 years of Company Service Credit

How to File a Claim for LTD Benefits

If you want to file a Claim for LTD benefits, see *Appendix A. Claims Procedures* of this SPD.

If you are no longer on the active payroll, there is a deadline for filing a Claim. You must file a Claim no later than 12 months after your last day on the payroll. In addition, you must have been Totally Disabled continuously from your last day on the payroll through the time you file your Claim.

You Are Required to Apply for Social Security Disability Benefits

When you file a Claim for LTD benefits, you must make application for Social Security disability benefits as soon as possible, since your LTD benefit calculation is based on the assumption that you will be receiving payments from Social Security. MetLife will provide you with assistance and support in

applying for Social Security benefits. MetLife will also provide assistance in the appeal process if your Social Security claim is denied.

On the other hand, if you show written proof that you have filed for Social Security benefits and actively pursued the Social Security benefits that you are eligible for, MetLife will begin paying your LTD benefit without estimating a Social Security benefit or reducing your LTD benefit. After your Social Security disability benefits start, your LTD benefits will be reduced by the amount of your Social Security disability benefits. You must reimburse MetLife for the amount of extra benefits that were paid to you by the Plan. If you fail to reimburse MetLife, MetLife will deduct it from future Plan payments.

MetLife will calculate and withhold an estimated Social Security benefit from your LTD payment if you do not make a good faith effort to seek a Social Security benefit before your LTD payments start.

Here are several reasons why it may be to your financial advantage to receive Social Security disability benefits:

1. Avoids reduced Social Security retirement benefits
2. Provides Medicare protection
3. Availability of a trial work period
4. The cost-of-living increases awarded by Social Security will not reduce your UCC disability benefits

If your Social Security application is denied, you will need to furnish proof of the denial to MetLife.

You Should File a Claim for Basic Life Insurance

When you file a Claim for LTD benefit payments, you should file a claim under The Dow Chemical Company Group Life Insurance Program's Union Carbide Subsidiary Basic Life Insurance Plan (the "Basic Life Insurance Plan"). See the summary plan description for the Basic Life Insurance Plan for more information and for how to file a claim for benefits under that plan. In calculating your LTD benefit, it will be assumed that you will receive a benefit for 5 years from the Basic Life Insurance Plan.

You Should File a Claim Under the Retirement Program for Disability Pension Benefits

If you have at least 8 years of Credited Service, you should consider applying for a disability pension from the Union Carbide Retirement Program. (See *Other Sources of Disability Benefits*). The disability pension will not be paid until you reach 10 years of Credited Service, and you must be considered Disabled at the time of disability. See the summary plan description for the Union Carbide Retirement Program for more information and for how to file a claim for benefits under that program.

Medical Examinations

If you are approved for LTD benefit payments, MetLife will have the right to have you examined at reasonable intervals by medical specialists (independent medical examiners) of their choice. The examination will be at MetLife's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial, suspension or termination of your benefits.

Payment of Unauthorized Benefits

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

- The amount of any other benefit paid to, or on behalf of, such Participant may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant to reimburse the Plan for benefits paid, including reasonable interest.
- If the person does not reimburse the Plan by the date determined by the Plan Administrator, the Plan Administrator may cancel coverage for the Participant and refuse re-enrollment.

The Plan Administrator may elect recoupment or reimbursement regardless of whether the excess benefit was provided by reason of the Plan Administrator's error or by reason of false, misleading, or inaccurate information furnished by the Participant.

Fraud Against the Plan

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

When Coverage Ends

Plan coverage ends if you terminate employment, cease to be in an eligible class of employees, or if the Plan is terminated. One way in which you cease to be in an eligible class of employees is if you receive benefit payments from The Dow Chemical Company Long Term Disability Income Protection Plan.

Funding

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

Your Legal Rights under ERISA

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

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

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

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

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

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

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

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

Plan Administrator's Discretion

The Plan Administrator is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Plan Administrator is listed in *Appendix 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 or capricious. For a detailed description of the Plan Administrator's and Claim Administrators' authority, see the Plan Document and *Appendix A. Claims Procedures*.

Plan Document

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

No Government Guarantee of Welfare Benefits

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

Amendment, Modification or Termination of Plan

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

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

a. Provide benefits under the Plan and pay expenses of administering the Plan; or

b. Provide cash for Participants, in accordance with applicable law.

Litigation

If you wish to file a lawsuit against the Plan (a) to recover benefits you believe are due to you under the terms of the Plan or any law; (b) to clarify your right to future benefits under the Plan; (c) to enforce your rights under the Plan; or (d) to seek a remedy, ruling or judgment of any kind against the Plan or the Plan fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Plan, then under the terms of the Plan you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA.

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

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the Plan or to clarify your right to future benefits under the terms of the Plan, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was

allegedly due, or (c) the date the Plan first repudiated its alleged obligation to provide such benefits;

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

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

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

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

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

Class Action Lawsuits

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

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

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

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

Privilege

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

- the Advisor's client is the Advisee and not any Employee, Participant, beneficiary, claimant, or other person;

- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and

- no Employee, Participant, beneficiary, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his or her Advisors with respect to whom a privilege applies, unless mandated by a court order.

Waiver

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

Providing Notice to Administrator

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

No Assignment of Benefits

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

Incompetent and Deceased Participants

Except as otherwise provided in an applicable Incorporated Document:

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

- Payments due to deceased Participants from claims made under a Program shall be made to the Participant's estate.

Uncashed Checks

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

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

For More Information

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

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Union Carbide Corporation Long Term Disability Plan (the "Plan"). However, this booklet is not all-inclusive and it is not intended to take the place of the Plan's legal documents.

Union Carbide Corporation reserves the right to amend, modify or terminate the Plan at any time in its sole discretion.

The Plan Document can be made available for your review upon written request to the Plan Administrator (listed in the ERISA Information section of this Summary Plan Description). The SPD and the Plan do not constitute a contract of employment. Your employer retains the right to terminate your employment or otherwise deal with your employment as if this SPD and the Plan had never existed.

ERISA Information

Union Carbide Corporation
Long Term Disability Plan
ERISA Plan #545
(A Welfare Benefit Plan)

Plan Sponsor	Union Carbide Corporation North America Benefits P.O. Box 2169 Midland, MI 48641 (800) 344-0661
Plan Administrator	The Plan Administrator is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Documents. The person, group of persons, or entity designated as Plan Administrator is listed in *Appendix 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 the Union Carbide Corporation Long Term Disability Plan (800) 344-0661
Type of Plan	Long-term disability insurance
Type of Plan Administration	Insurer administration
Employer Identification Number	13-1421730
Plan Number	545
Claims Administrator for Claims for Plan Benefits	**To submit a Claim for Plan Benefits:** MetLife Disability P.O. Box 14590 Lexington, KY 40511-4590 Attention: Union Carbide Corporation Long Term Disability Plan **To appeal a denied Claim for Plan Benefits:** MetLife Disability P.O. Box 14592 Lexington, KY 40511-4592 Attention: Claims Administrator for Union Carbide Corporation Long Term Disability Plan (Appellate Review)

Claims Administrator for a Claim for an Eligibility Determination	The Claims Administrator for a Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Documents. The person, group of persons, or entity designated as Claims Administrator for a Claim for an Eligibility Determination is listed in *Appendix B. 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 Union Carbide Corporation Long Term Disability Plan (Eligibility Determination) (800) 344-0661 *Appeals Administrator:* The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attention: Appeals Administrator for Union Carbide Corporation Long Term Disability Plan (Eligibility Determination) (800) 344-0661
To Serve Legal Process	General Counsel The Dow Chemical Company Corporate Legal Department Global Dow Center 2211 H.H. Dow Way Midland, MI 48674
Plan Year	The Plan's fiscal records are kept on a plan year beginning January 1 and ending December 31.
Funding	Plan benefits are insured by a group insurance contract with MetLife. The Company pays for the premiums on this insurance contract from its general assets. Assets of the Plan (if any) may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as the Plan may be amended from time to time, as well as to pay for any expenses of the Plan. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses.

Appendix A.
Claims Procedures

You Must File a Claim in Accordance with these Claims Procedures

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

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

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

Deadline to File a Claim and File Proof of Claim

Claims for Plan Benefits

If you are no longer on the payroll of a Participating Employer, you must file your Claim within 12 months of your last day on the payroll. Failure to file a Claim within the 12-month limitation period will result in a denial of your Claim.

Claims for an Eligibility Determination

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

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 B. Named Fiduciaries*.

Claims for Plan Benefits

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

Authority of Claims Administrators and Your Rights Under ERISA

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

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

An Authorized Representative May Act on Your Behalf

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

Claims for Eligibility Determinations

Information Required In Order to Be a "Claim"

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

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

Claims for Eligibility Determinations must be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Initial Claims Reviewer for Union Carbide Long Term Disability Plan (Eligibility Determination)

Initial Determination

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

Appealing the Initial Determination

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

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

Appeals of Eligibility Determination Claims should be sent to:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Appeals Administrator for Union Carbide Corporation Long Term Disability Plan
(Appeal of Eligibility Determination)

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

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

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

If your Claim is denied, in full or in part, the written notification of the decision will state: (1) the reason(s) for the denial; (2) refer to the specific provisions in the Plan Document on which the denial is based; (3) that you are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to your Claim (as determined by the Claims

Administrator under applicable federal regulations); and (4) that you have a right to bring a civil action under section 502 of ERISA.

Claims for Plan Benefits

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

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Plan Administrator for Union Carbide Corporation Long Term Disability Plan
(800) 344-0661

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

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

Initial Determination

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

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

For Claims Filed on or before April 1, 2018

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

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

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

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

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

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

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

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

For Claims Filed after April 1, 2018

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

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

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

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

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

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

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

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

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

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

Appealing the Initial Determination

If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. In addition, if you were being paid benefits and you have been notified that these benefits will be terminated, you may also appeal the decision to terminate your benefits. You must file a written appeal within 180 days of receipt of the notice of denial from the Initial Claims Reviewer for Claims for Plan Benefits, assuming that there are no extenuating circumstances, as determined by the Appeals Administrator for Claims for Plan Benefits, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

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

Send your appeal to:

MetLife Disability
P.O. Box 14592
Lexington, KY 40511-4592
Attention: Claims Administrator for Union Carbide Corporation Long Term Disability Plan (Appellate Review)

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

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

- Deference will *not* be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The person who will review your appeal will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim.
- The Appeals Administrator will take into account all comments, documents, records, and other information submitted to the Appeals Administrator for Claims for Plan Benefits that is related to the Claim without regard to whether such information was submitted or considered in the initial determination.

- If the initial determination was based on medical judgment, the Appeals Administrator for Claims for Plan Benefits will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person consulted in connection with the initial determination, and will not be a subordinate who reports to the person who was consulted in connection with the initial determination.
- The Appeals Administrator for Claims for Plan Benefits will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial decision, without regard to whether the advice was relied upon in making the initial decision.
- In addition, for Claims for Plan Benefits arising after April 1, 2018, the Appeals Administrator for Claims for Plan Benefits will provide you with the following information, free of charge, as soon as possible and in advance of the deadline for notifying you of the Appeals Administrator for Claims for Plan Benefits' decision:
    - Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit decision in connection with the Claim; and
    - Any new or additional rationale for issuing an adverse benefit decision on appeal.

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

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

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

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

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

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

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

advice was relied upon in denying your appeal; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits);

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

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

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

Appendix B.
Named Fiduciaries as of April 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 April 1, 2019. However, the Named Fiduciaries may be changed from time to time. For inquiries about the persons or entities currently serving as Named Fiduciaries, call 833-693-6947 or visit www.dowbenefits.com.

Named Fiduciary	Dow Title	Named Individual	Effective Date
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Jamye Gallihugh	January 1, 2019
Initial Claims Reviewer for Claims for an Eligibility Determination	Benefits Representative	Elaine Rabideau	April 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	Benefits Plan Manager	Holly Gerisch	January 1, 2019
Appeals Administrator for Claims for an Eligibility Determination	North America Benefits Leader	Ryan Marra	January 1, 2019
Plan Administrator	Global Benefits Director	Bryan Jendretzke	January 1, 2019
Plan Administrator	Benefits Plan Manager	Holly Gerisch	January 1, 2019