Summary Plan Description for:

Life, Disability and other Group Insurance Benefits

APPLICABLE TO ELIGIBLE ACTIVE EMPLOYEES

Effective January 1, 2021

This Summary Plan Description ("SPD") supersedes all prior SPDs. Copies of updated SPDs (including this SPD) are available online at www.dowbenefits.com. You may also request a copy, free of charge, from HR Solutions at (833) 693-6947 or by submitting your request through the Dow U.S. Benefits Site's Message Center at http://dowbenefits.ehr.com. Summaries of material modifications may also be published from time to time in separate documents.

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Section 1. ERISA Information

Summary Plan Description for
Life, Disability and other Group Insurance Benefits

The Life, Disability and other Group Insurance Benefits Program (the "Program") is comprised of a number of legal plans (referred to individually as the "Plan" or collectively as the "Plans") that may be governed by the Employee Retirement Income Security Act of 1974 ("ERISA") and identified in the Appendices to this SPD. This section provides important legal and administrative information. Information that is specific to each Plan may be found in the Appendices to this SPD.

If you have any questions about any of the information contained in this SPD, contact the Plan Administrator.

Type of Plan	The Plans are ERISA welfare benefit plans providing certain life insurance, legal services, voluntary accident insurance, business travel accident insurance, occupational accident insurance, corporate-owned life insurance, and long term disability insurance to certain eligible employees. These are collectively referred to in this SPD as the "Benefit Programs."
Type of Plan Administration	Except where otherwise noted in the Appendices, the Benefit Programs of the Plans are fully-insured by the Insurers listed in the Appendices pursuant to group insurance contracts entered into between The Dow Chemical Company (the "Company" or "Dow") and the Insurers. For fully-insured benefits, premiums are paid to the Insurers from the Company's general assets. The Insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-funded benefits, the Company is responsible for paying benefit claims from its general assets.
Plan Sponsor	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641
Employer Identification Number	38-1285128
Plan Administrator	The Dow Chemical Company North America Benefits P.O. Box 2169 Midland, MI 48641 Attn: Plan Administrator (877) 623-8079

The Plan Administrator is your primary source of information about the Plan. The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.

HR Solutions

The Dow Chemical Company
HR Solutions
P.O. Box 2169
Midland, MI 48674
(833) 693-6947

Eligibility Claims Administrator

To submit a Claim for an Eligibility Determination:

Dow HR Solutions
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attn: Initial Claims Reviewer (Claim for Eligibility Determination)

To appeal a denied Claim for an Eligibility Determination:

Dow HR Solutions
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attn: Appeals Administrator

Agent for Service of Legal Process

The Dow Chemical Company
2030 Dow Center
Midland, MI 48674
Attn: General Counsel

Legal process on the Plan may also be served on the Plan Administrator.

Plan Year

The Plan Year is January 1 to December 31.

Section 2. Introduction

This is the SPD for certain life and disability insurance benefits offered under the Program, including life insurance, grief counseling services, legal services, voluntary accident insurance, business travel accident insurance, occupational accident insurance, corporate-owned life insurance, long term care insurance, and long term disability insurance. The provisions of this SPD apply only to active employees. This SPD supplements each certificate of insurance (or

evidence of coverage) produced by the Insurer for each of the Benefit Programs (the "Certificates") and the current annual enrollment materials. The Certificates and current annual enrollment materials are incorporated into this SPD for the Program.

The Plans are governed by the plan documents for the Program, which are the legal instruments under which the Program is operated. If there is a conflict between this SPD and the Plan document, the Plan document shall govern. You may request a copy of the Plan document from the Plan Administrator.

This SPD contains important information about your benefits under the Plans. However, it does not contain all of the information that may pertain to your benefits. Further information can be found in the Plan Document for the applicable Program. You may request a copy of the applicable Plan Document from the Plan Administrator.

The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and any of the Plans offered under the Program) at any time in its sole discretion.

Capitalized words in this SPD are defined either in the Plan document, or in *Section 21. Definitions of Terms*, or in the applicable Appendix for the specific Plan.

The words "they", "them", and "their" shall include all genders, unless the context clearly indicates to the contrary. Article and Section headings are included for convenience of reference and are not intended to add to, or subtract from, the terms of the Plan.

Section 3. Eligibility

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

Additional rules regarding eligibility for each Plan may be reflected in the Appendix for the Plan.

Section 4. Enrollment

Enrollment may be automatic or may require active enrollment on the Dow U.S. Benefits Site.

Additional information regarding enrollment for each Plan may be reflected in the Appendix for the Plan.

Section 5. Fraud Against the Program

If you intentionally misrepresent information to the Program or Plan, knowingly withhold relevant information from the Program or Plan, or deceive or mislead the Program or Plan, the Plan Administrator may (1) terminate your participation in the Plan, either retroactively to the date deemed appropriate by the Plan Administrator, or prospectively; (2) require you to reimburse the Plan for amounts it 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 Program. In addition, your employer may terminate your employment, pursue civil and/or criminal action against you, or take other legal action. If you or your Dependent(s) 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 and your Dependent(s) are not eligible for coverage under the Program.

Section 6. Your Legal Rights Under ERISA

As a Participant in the Program, you are entitled to certain rights and protections under ERISA. This law requires that all Program 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 Program, including insurance contracts, collective bargaining agreements (if applicable), the Plan Document, and the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Program, including insurance contracts, collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series), the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

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

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

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

Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits which is denied or ignored, you may file suit in a state or federal court. If it should happen that Program fiduciaries misuse the Program'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. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. For more information regarding enforcing your rights in court, see *Section 11. Litigation and Class Action Lawsuits*.

Assistance with your Questions: If you have any questions about the Program, you should contact the Plan Administrator. For the contact information for the Plan Administrator, see *Section 1. ERISA Information*. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Section 7. Plan Administrator's Discretion

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, adopt rules and procedures applicable to matters they are authorized to decide and delegate certain authority and responsibilities that they have with respect to the Plans. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if

challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claims Administrators' authority, see the Plan document and *Section 18. Claims Procedures*.

Section 8. Plan Document

The Program will be administered in accordance with its terms. If 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 Plan Administrator, in the exercise of their best judgment and sole discretion, based on their understanding of the Plan Sponsor's intent in establishing the Plan and taking into account all evidence (written and oral) that they deem appropriate or helpful.

Section 9. No Government Guarantee of Welfare Benefits

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

Section 10. Dow's Right to Terminate or Amend the Program

The Company reserves the right to amend, modify or terminate the Program and any or all of the Plans (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 Plans are set forth in the Plan document.

If the Company terminates a 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 11. Litigation and Class Action Lawsuits

11.1 Litigation

If you wish to file a lawsuit against the Program or Plan (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 *Section 18. Claims Procedures* and you must file the suit within the Applicable Limitations Period or your suit will be time-barred. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA. (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 one individual, the Applicable Limitations Period applies separately with respect to each individual.

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

The Applicable Limitations Period replaces and supersedes any limitations period that ends at a later time that otherwise might be deemed applicable under any state or federal law. The Applicable Limitations Period does not extend any limitations period under state or federal law.

11.2 Class Action Lawsuits

Legal actions against the Program or the Plan 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 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 Program, all parties to such action that are related to the Program (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.

Section 12. Incompetent and Deceased Participants

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

Section 13. Waivers

A term, condition, or provision of the Program 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 14. Providing Notice to Administrator

No notice, election or communication in connection with the Program that you, a Dependent 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 15. Funding

Dow covers the entire premium for coverage under some of the Plans, and for other Plans Dow shares the premium costs with Employees. For this Plans for which an Employee contribution is required, Employee contributions are generally made through payroll deduction. Except where otherwise noted in the Appendices, benefits are paid from insurance policies.

Any assets of the Program may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Program, as the Program is amended from time to time, as well as to pay for any expenses of the Program. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees, and other administrative expenses.

Additional information regarding funding for a Plan are reflected in the Appendix for the Plan.

Section 16. Uncashed Checks

For any benefits paid out of general corporate assets, 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 and the forfeited amounts will be used to offset Plan administrative expenses.

The 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.

Section 17. Payment of Unauthorized Benefits

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

- The amount of any other benefit paid to, or on behalf of, such Participant, Dependent, beneficiary, or other person under the Program may be reduced by the amount of the excess payment.
- The Plan Administrator may require the Participant, Dependent, beneficiary, or other person to reimburse the Program for benefits paid, including reasonable interest.
- If the person does not reimburse the Program 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 under the Program, 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 Employee or their estate.

Section 18. 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 Claim requesting that the applicable Plan pay for benefits covered under the applicable Plan. Claims procedures for plan benefits are described in each Appendix.

- A *Claim for an Eligibility Determination* is a Claim requesting a determination as to whether a claimant is eligible to be a Participant under the applicable Plan or the Program or as to the amount a claimant must contribute towards the cost of coverage. Claims procedures for eligibility determinations are described in Section 18.

You must follow the Claims Procedures for either Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation.

18.1 Who Will Decide Whether to Approve or Deny My Claim?

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

- *Claims for Plan Benefits*. The Initial Claims Reviewer and the Appeals Administrator are provided in the applicable Appendix.
- *Claims for an Eligibility Determination*. The Initial Claims Reviewer and the Appeals Administrators are provided in *Section 1. ERISA Information*.

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 Program and to make findings of fact in order to carry out their respective decision-making responsibilities. 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 Program under Section 502 of ERISA in federal court, provided you complete the claims procedures described in this *Section 18. Claims Procedures* (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 *Section 11.1 Litigation* for the deadline for filing a lawsuit.

18.2 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 Program will recognize a person as a 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 also will be recognized by the Program.

18.3 How to File a Claim for an Eligibility Determination

Information Required In Order to Be a Claim

The following information must be submitted in writing to the Initial Claims Reviewer in order to be a "Claim":

- The name of the Employee (or former Employee), and the name of the person (Employee, Dependent, Survivor, as applicable) who is requesting the eligibility determination;
- The name of the Plan for which the eligibility determination is being requested; and
- If the eligibility determination is being requested for the Employee's dependent:
    - a description of the relationship of the dependent to the Employee (e.g., Spouse/Domestic Partner, Dependent Child, etc.); and
    - documentation of such relationship (e.g., marriage certificate/statement of Domestic Partnership, birth certificate, etc.).

Claims for an Eligibility Determination must be sent to the Initial Claims Reviewer at the address provided in *Section 1. ERISA Information*.

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 of the date you submitted your Claim; except that under special circumstances, the Initial Claims Reviewer can 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 Program 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:

- The name of the Employee;
- The name of the Dependent, if the Dependent is the person who is appealing the Administrator's decision;

- The name of the 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 address provided in *Section 1. ERISA Information*. You may submit any additional information to the Appeals Administrator when you submit your request for appeal. You also may 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 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 is not 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 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 can 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 indicate 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 Program, 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.

The Appeals Administrator will notify you in writing of its decision. 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.

18.4 How to File a Claim for Plan Benefits

The Insurers and third party administrators of the Plan are responsible for evaluating all benefit claims under the Plans. The Insurers and third party administrators will decide all claims in accordance with their reasonable claims procedures, as required by ERISA and applicable state laws. The Insurers and third party administrators have the full power to interpret and apply the terms of the Plans as they relate to the benefits provided under the applicable insurance contract, group policy or certificate of insurance.

To obtain benefits from an Insurer or third party administrator under a particular Plan, you must follow the claims procedures under the applicable insurance contract, group policy or certificate of insurance and described in the applicable certificate, policy or booklet. The Insurers and third party administrators have the right to seek independent medical advice and to require you to provide other evidence as they deem necessary to decide your claims and appeals.

If the Insurer or third party administrator denies your claim, in whole or in part, you will receive a notice of the denial and an explanation of how you may appeal the decision, as required by ERISA. Except as may be otherwise required by law, the final decision of the Insurer or third party administrator will be binding on all parties. You must exhaust all required appeals prior to bringing any civil suit under ERISA.

Refer to the applicable Appendix below for a description of the claims and appeals procedures under a particular Benefit Program or Plan.

Section 19. Tax Consequences of Coverage and Benefits

Neither the Company, nor any Participating Employer or any other affiliate, makes any assertion or warranty about (1) health care services and supplies that a Participant obtains, or obtains reimbursement for, as Plan benefits; or (2) the tax treatment of Plan coverage or benefits. The Participant shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

Additional information regarding tax consequences for a Plan are reflected in the Appendix for the Plan.

Section 20. Assignment of Benefits

In general, except to the extent required by law or otherwise provided in the Plan document or SPD, benefits payable under the Program shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or change of any kind. You may direct that benefits payable to you be paid instead to a provider or to a person who has agreed to pay for any benefits payable under the Program. The Program reserves the right to make payment directly to you, however.

Additional information regarding assignment for a Plan are reflected in the Appendix for the Plan.

Section 21. Definitions of Terms

The following are some of the defined terms of the Program. Additional terms are defined in the Plan document, the underlying insurance policy and/or the Appendices. A copy of the Plan document is available upon request.

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

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 *Section 18. Claims Procedures*.

Claim for an Eligibility Determination
A Claim requesting a determination as to whether a claimant is eligible to be a Participant under a Plan or the Program 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
The Dow Chemical Company.

Dependent
An Employee's Spouse, Domestic Partner, or Dependent Child(ren), or a child to whom a Qualified Medical Child Support Order applies.

Domestic Partner
A person who is a member of a "Domestic Partnership". A "Domestic Partnership" means a relationship between two people that meets all of the requirements of paragraph a, or both of the requirements of paragraph b:

a. Requirements of paragraph a (Facts and Circumstances Test):

1. the two people have lived together for at least 12 consecutive months immediately prior to receiving coverage under the Program,

2. the two people are not Married to other persons and were not Married to other persons at any time during the 12 consecutive month period preceding coverage under the Program,

3. the two people are and were, during the 12 consecutive month period preceding coverage under the Program, each other's sole Domestic Partner in a committed relationship similar to a legal Marriage and with the intent to remain in the relationship indefinitely,

4. both people are legally competent and able to enter into a contract,

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

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

7. during the 12 month period preceding coverage under the Program, the two people have been and are financially interdependent with each other, and

8. both people signed a statement acceptable to the Plan Administrator indicating the above requirements have been met and provided it to the Plan Administrator.

b. Requirements of paragraph b (Civil Union Test):

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

2. both people signed a statement acceptable to the Plan Administrator and provided it to the Plan Administrator.

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

Employee
A person who:

- 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;
- receives a payment for services performed for the Participating Employer directly from a Participating Employer’s U.S. Payroll Department;
- if not a U.S. citizen or a U.S. resident alien, is Localized in the U.S.; and
- if on international assignment, is either a U.S. citizen or Localized in the U.S.

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

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 whom 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 Program, regardless of whether the determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters or whether you are subsequently treated or classified as an Employee for certain specified purposes. Any change to your status by reason of reclassification or subsequent treatment will apply prospectively only (*i.e.*, will apply to costs that are incurred and eligible for reimbursement under the terms of the Program, after your reclassification).

Full-Time
Classified by the Participating Employer as having Full-Time status.

Less-Than-Full-Time
An Employee who has been approved by the Participating Employer to work 20 to 39 hours/week and is classified by the Participating Employer as having "Less-Than-Full-Time Status."

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

LTD Participant
A former Employee who is receiving a long term disability payment from The Dow Chemical Company Long Term Disability Program who meets the eligibility requirements for the Program, is enrolled in coverage under the Program, and remains eligible for benefits under the Program.

Married or Marriage
A legal marriage between two individuals for federal tax purposes. The Program does not recognize common law marriages except that:

1. If an Employee was a participant of a plan of The Dow Chemical Company Medical Care Program before November 1, 1993, and had a common law Spouse recognized under the laws of the state in which they resided, and if the common law Spouse was covered as a Dependent under a Dow Medical Plan before November 1, 1993, then such common law Spouse is deemed under the Program to be Married to the Employee;

2. Effective January 1, 1996, the Program recognizes a marriage that meets the requirement of Texas Family Code Annotated section 2.402; and

3. Effective January 1, 2002, common law Spouses of UCC employees and former UCC employees who were covered under a UCC medical plan at any time

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between February 5, 2001, and December 31, 2001, as “spouses” of UCC employees will be deemed to be “Married” for purposes of the Program.

Participant
An Employee, Dependent or such other individual who meets the eligibility criteria of the Program, elects to participate in the Program, and remains eligible for benefits under the Program.

Participating Employer
The Company or one of its subsidiaries that has been authorized by the Company to participate in the Program. “Participating Employers” and “Dow” have the same meaning and are used interchangeably. Notwithstanding anything to the contrary, a “Participating Employer” is only a “Participating Employer” while it is a member of the Company’s controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company’s controlled group of corporations, then the entity ceases to be a “Participating Employer” on the date it is no longer a member of the controlled group of corporations.

Regular Employee
An Employee who is classified by the Employer as “regular.”

Rohm and Haas (or “ROH”)
Rohm and Haas Company and certain of its subsidiaries.

Salaried
Not represented by a collective bargaining unit.

Spouse
A person who is Married to an Employee (or other individual eligible for coverage under Section 3 of this SPD).

UCC or Union Carbide
Union Carbide Corporation and certain of its subsidiaries.

Section 22. For More Information

For more information regarding the provisions in this SPD, please contact the Dow HR Services Center using the contact information in *Section 1. ERISA Information*.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Program. However, it is not all-inclusive and it is not intended to take the place of the Program’s legal documents. The Dow Chemical Company reserves the right to amend, modify or terminate the Program (and any underlying 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. The SPD and the Program shall not confer employment rights upon any person.

No person shall be entitled by virtue of the SPD or the Program to become or to remain in the employ of the Company and nothing in the SPD or the Program shall restrict the right of the Company to terminate the employment of any eligible employee or other person at any time.

Section 23. Appendix A. Life Insurance Information

23.1 Life Insurance 1

Former SPD Name:	The Dow Chemical Company Company-Paid Life Insurance Plan, Employee-Paid Life Insurance Plan, Dependent Life Insurance Plan
Legal Plan Name:	The Dow Chemical Company Group Life Insurance Program
Legal Plan Number:	Plan 507
Claims Administrators 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

ADDITIONAL ELIGIBILITY INFORMATION

Salaried Employees

Salaried Employees of a Participating Employer who have regular, active, Full-Time, or Less-Than-Full-Time status, are receiving partial disability payments under the Dow LTD Program, or are in the apprenticeship program are eligible and are automatically covered under this Plan.

Hourly Employees

Eligibility of Hourly Employees depends on whether the applicable collective bargaining unit and the Participating Employer have agreed to this Plan. If the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Plan, then the terms of such collective bargaining agreement shall govern. If the terms of the collective bargaining agreement specify that Hourly Employees shall be provided this Plan, but do not specifically address the category of Employees that are eligible or not eligible, then regular, active Employees with Full Time status and Employees receiving partial disability payments under the Dow LTD Program, or in the apprenticeship program who are members of the collective bargaining unit are eligible for coverage under the Plan.

Non-U.S. Employees on International Assignment Outside the U.S. ("Outbound Employees")

If you are employed by the Company or one of its subsidiaries or affiliates to perform personal services in an employer-employee relationship that is not subject to taxation under the Federal Insurance Contributions Act or similar federal statute; are not a U.S. citizen or resident alien; were working in the U.S.; are on international assignment initiated by your employer outside the U.S. and are expected to return to the U.S. for employment with a Participating Employer; receive payment for services performed for your employer from DCOMCO; and are not otherwise eligible for a death benefit from a group life contract based on your employment with the Company or one of its subsidiaries or affiliates, you are eligible and are automatically covered under this Plan if you are a citizen of a country on file with the Plan Administrator.

However, if your employer ceases to be a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code, then you will no longer be eligible to participate in the Plan on that date. In addition, Company-Paid Life Insurance coverage ends on the date you retire in accordance with your employer retirement plan.

Employees on a Leave of Absence

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by a Participating Employer, such as an approved leave under the Company's Military Leave Policy, Family Leave Policy, Paid Medical Leave Policy, unpaid leave policy, or a period during which you receive partial disability payments under the Dow LTD Program. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. For more details on benefits continuation during an approved leave of absence, please refer to the HR Portal KnowledgeBase articles for various leaves of absence, which are incorporated into the Plan and this SPD by reference.

Disabled Employees

If you are being paid a benefit from the Dow LTD Program, The Dow Chemical Company Michigan Hourly Contract Disability Plan, The Dow Chemical Company Texas Operations Total and Permanent Disability Plan, or the DCC LTD Plan, you may be eligible under the Plan. See the Special Coverage for Certain Disabled Persons section of this Appendix.

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for life insurance coverage until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. See the Special Coverage for Certain Disabled Persons section of this Appendix.

Eligibility Determinations

The Claims Administrator for Claims for an Eligibility Determination determines eligibility to participate in the Plan. The Claims Administrator is a Plan fiduciary and has full discretion to interpret the provisions of the Plan and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants (except to the

extent that determinations by the Initial Claims Reviewer are subject to review by the Appeals Administrator).

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan or have been told that you are not, you must follow the Claims Procedures outlined in Section 18.

ADDITIONAL ENROLLMENT INFORMATION

If you are eligible for the Plan, you are automatically enrolled in Plan coverage. Completing an enrollment form is necessary only to name your beneficiary. You may waive coverage. If you want to waive coverage, you must provide written notification to HR Solutions in a form and manner acceptable to the Plan Administrator. If you waive coverage, you waive coverage permanently including, if applicable, any Retiree coverage. You may not re-enroll in this Plan at any time in the future.

EMPLOYEE CONTRIBUTION

Dow provides Company-Paid Life Insurance at no cost to you. However, see "Additional Tax Consequences," below for a description of imputed income that may apply.

COVERAGE DETAIL

Amount of Coverage

The amount of coverage is based on your annual pay:

- For Salaried employees, Inbound Employees, and Outbound Employees, base annual salary is used to calculate the life insurance amount.
- For Bargained-for employees, annual pay is calculated using your base hourly rate. For Deer Park Bargained-for employees who receive a Department Relief Operations (DRO) premium, the DRO premium is added to base hourly rate in the annual pay calculation.
- For apprenticeship program Employees, whether Salaried or Bargained-for, annual pay is calculated using your base hourly rate.

<u>Maximum Coverage</u>

The maximum amount of coverage available is $1.5 million.

<u>Coverage for Salaried Employees and for Hourly Employees Whose Collective Bargaining Unit Has Agreed to this Plan</u>

In general, the Plan provides coverage of one times (1x) your base annual salary, rounded up to the next $1,000.

A special rule applies to Michigan Operations Hourly Employees who were not Actively at Work on January 1, 2008, but continue to be on the payroll (for example due to a paid medical leave of absence). If such an individual was covered at 1/2x prior to January 1, 2008, they may continue 1/2x coverage as long as they continue to be on the payroll. If they return to work, coverage will increase to 1x when they are Actively at Work.

Your coverage is automatically adjusted as your base salary changes, provided you are Actively at Work. If you are Less-Than-Full-Time, your 1x coverage is based on your Full-Time base annual salary, and coverage is automatically adjusted as your base salary changes. Whether you are Full-Time or Less-Than-Full-Time, if you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

Coverage for Inbound Employees

If you are an Inbound Employee (as defined in this Appendix), the Plan provides coverage of two times (2x) your base annual salary, rounded up to the next $1,000.

Your coverage is adjusted periodically as your base salary changes, provided you are Actively at Work. If you are Less-Than-Full-Time, your 2x coverage is based on your Full-Time base annual salary, and coverage is adjusted periodically as your base salary changes. Whether you are Full-Time or Less-Than-Full-Time, if you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

Coverage for Outbound Employees

If you are an Outbound Employee (as defined in this Appendix), the Plan provides coverage of two times (2x) your base annual salary, rounded up to the next $1,000.

Your coverage is adjusted periodically as your base salary changes, provided you are Actively at Work. If you are Less-Than-Full-Time, your coverage is based on your Full-Time base annual salary, and coverage is adjusted periodically as your base salary changes. Whether you are Full-Time or Less-Than-Full-Time, if you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

Special Coverage for Certain Disabled Persons

Dow LTD Program

If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan and you have been approved to receive benefit payments from the Dow LTD Program, you are eligible for Plan coverage under the following circumstances:

- If your date of "full disability" (as defined under the Dow LTD Program) is on or after January 1, 2006, you are eligible for coverage when your LTD benefit payments begin. The following applies to you:
    - If you were hired by Dow or Union Carbide on or after January 1, 2008, or you have less than ten (10) years of Service under the Dow Employees' Pension Plan or the Union Carbide Employees' Pension

Plan, you are eligible for up to either 12 months or 24 months of company paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service, but less than ten (10) years of Service.

  - If you were hired by Dow or Union Carbide prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), and you have ten (10) or more years of Service, you are eligible for coverage until you are no longer eligible to receive payments from the Dow LTD Program. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.
  - If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of company paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

- If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were hired prior to January 1, 2003 and you have ten (10) or more years of Service, you are eligible for company paid life insurance coverage until you are no longer eligible to receive LTD benefits.
- The amount of coverage is the same as the amount of coverage you had on the date you were last Actively at Work. Currently, the Company pays the cost of this coverage.
- If your date of "full disability" (as defined under the Dow LTD Program) is prior to January 1, 2006, the following applies to you:
  - You are eligible for Plan coverage until you are no longer eligible to receive payments from the Dow LTD Program, at the same amount of Plan coverage you had on the date you were last Actively at Work, up to one times (1x) your base annual salary. Currently, the Company pays the cost of this coverage.
  - You are also eligible for an additional amount of coverage, which is determined by the amount of Employee-Paid Life coverage you were enrolled in as an active Employee immediately prior to being approved to receive payments from the Dow LTD Program, but not to exceed 1x. (For example, if you were enrolled for 6x as an active

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Employee, your coverage would be reduced to 1x.) Currently, the Company pays the cost of this coverage, and this coverage continues until you are no longer eligible to receive payments from the Dow LTD Program.

- If you are "partially disabled" (as defined under the Dow LTD Program), the following applies to you:
  - You are eligible for Plan coverage as described above under Coverage for Salaried Employees and for Hourly Employees Whose Collective Bargaining Unit Has Agreed to this Plan. In general, this means the Plan provides coverage of one times (1x) your base annual salary, rounded up to the next $1,000. Your base annual salary will be determined as if you were still working your pre-disability schedule.

Texas Total and Permanent Disability

If (1) you were enrolled in The Dow Chemical Company Texas Operations Hourly Total and Permanent Disability Plan (the "T&P Plan"), (2) you were deemed to be "totally and permanently disabled" by the plan administrator of the T&P Plan, and (3) it was determined that you are eligible to be in benefits pay status by the plan administrator of the T&P Plan, then you are eligible for coverage under the Plan equal to the amount of coverage you were enrolled in under the Texas Operations Hourly Optional Life Insurance Contributory Plan (Contributory Life) at the time you became totally and permanently disabled. Coverage ends the earlier of (1) the date as of which you are determined to no longer be "totally & permanently disabled" by the plan administrator of the T&P Plan, and (2) the date you reach age 65.

Contract Disability Participants

If (1) you have been determined to be "totally and permanently disabled" by the claims administrator of The Dow Chemical Company Michigan Hourly Contract Disability Plan (the "Contract Disability Plan") and (2) you are receiving benefit payments from the Contract Disability Plan, then you are eligible to receive the same company-paid life insurance coverage that you had as an active Employee. Coverage ends the earlier of (1) the date as of which no longer are eligible for benefit payments under the Contract Disability Plan and (2) the date you reach age 65. If you were Actively at Work at age 65 or older and subsequently became approved for benefits by the Contract Disability plan administrator, your coverage will be determined by applying the appropriate percentage from the following table to your base annual hourly rate effective the day before you qualified to receive benefit payments under the Contract Disability Plan, with a minimum of $5,000.

YOUR AGE	**PERCENTAGE**
65	50 percent
66	30 percent

67	10 percent
68	5 percent

On and after your 70th birthday, the amount of your Retiree Company-Paid Life Insurance benefits will be $5,000. Currently, the Company pays the cost of this coverage.

Rohm and Haas Company Long Term Disability Participants

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for life insurance coverage at the same level of coverage you had immediately prior to your disability, if (1) your qualifying disability was incurred prior to January 1, 2010, and (2) you continue to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. Such coverage continues at no cost to you until you are no longer eligible to receive disability payments from that Program.

DCC LTD Plan

Certain disabled individuals of DCC are eligible to continue participating in the life insurance program. In general, to the extent that you are eligible for life insurance coverage as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as an Employee of Dow, unless otherwise stated.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for life insurance coverage until you are no longer eligible to receive payments from LTD.

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2017:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for life insurance coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).

You will be considered "retired" and thus ineligible for the Program as a DCC LTD Participant as follows:

Age Became Disabled	Date Considered "Retired"
Less than 60	Date reach age 65
60-64	Date that is 5 years after received first payment under the DCC LTD Plan
65-68	Date reach age 70
69 or older	Date that is 12 months after received first payment under the DCC LTD Plan

If you were disabled under the DCC LTD Plan on December 31, 2016, you are eligible for Plan coverage on and after January 1, 2017, equal to the amount of coverage you would have received under the DCC Life Plan as follows:

Your life insurance will equal 1x your base annual earnings on your last day of active work, plus $5,000 after age 65. At age 66, your coverage multiplier is reduced 20 percent each year until you reach age 70. At age 70 and beyond, your coverage amount is $5,000. The following chart summarizes the insurance coverage for employees disabled under the DCC LTD Plan.

AGE	COVERAGE AMOUNT
UNDER 65	1 times base annual earnings*
65	1 times base annual earnings*, plus $5,000
66	0.8 times base annual earnings*, plus $5,000
67	0.6 times base annual earnings*, plus $5,000
68	0.4 times base annual earnings*, plus $5,000
69	0.2 times base annual earnings*, plus $5,000
70	$5,000

*** "BASE ANNUAL EARNINGS" MEANS AN EMPLOYEE'S BASE ANNUAL EARNINGS ON THEIR LAST DAY OF ACTIVE WORK.**

In general, coverage ends when you are no longer receiving benefits under the DCC LTD Plan. Refer to the applicable life insurance policy for further details.

Effective Dates of Coverage

Beginning

Your coverage begins on your first day of active employment as an eligible Employee of a Participating Employer.

Ending

Your Company-Paid Life Insurance coverage ends on the earliest of:

- the date the group policy ends;
- the date the Plan terminates;
- the date you no longer meet the eligibility requirements of the Plan;
- the date you elect to terminate your coverage; or
- the date your employment ends.

PORTING COVERAGE TO A SEPARATE GROUP TERM LIFE POLICY

(If you are an Inbound Employee or an Outbound Employee, this section does not apply to you and you are not eligible to port coverage.)

If your Company-Paid Life Insurance coverage under the Plan ends or is reduced because:

- You become retired or your employment ends; or
- You cease to be in a class that is eligible for this coverage; or
- Dow cancels the MetLife group life insurance policy or amends the Plan to exclude or change the amount of coverage for your work group; then the amount of coverage you lost may be continued on a direct bill basis with MetLife through the portability feature. Portability allows (former) employees 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 active 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 in any combination of Company-Paid Life and Employee-Paid Life Insurance. However, if your Company-Paid Life Insurance coverage under the Plan ends because Dow has cancelled the Company-Paid Life Insurance coverage under the MetLife group life insurance policy or because Dow has amended the Plan to exclude coverage for your work group, the maximum amount you may port is limited to the lesser of:

- the amount of your Company-Paid Life Insurance and Employee-Paid 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 (Barnum Financial Group) to offer you advice on the options available to you. You may receive a call from a local, specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor any Participating Employer 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.

CONVERTING TO AN INDIVIDUAL NON-TERM LIFE POLICY

(If you are an Inbound Employee or an Outbound Employee, this section does not apply to you and you are not eligible to convert to an individual policy.)

If your Company-Paid Life Insurance coverage under the Plan is reduced due to retirement, the amount of coverage you lost 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 Company-Paid Life Insurance you lost under the Plan.

If your Company-Paid Life Insurance coverage under the Plan ends because your employment ends, your 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 Company-Paid Life Insurance in effect for you under the Plan on the date your employment ends.

If your Company-Paid Life Insurance coverage under the Plan ends because Dow has cancelled the Company-Paid Life Insurance coverage under the MetLife group life insurance policy, or Dow has amended the Plan to exclude coverage for your work group, you may convert your Company-Paid 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 Company-Paid 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 Dow 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 (Barnum Financial Group) to offer you advice on the options available to you. You may receive a call from a local,

specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor any Participating Employer 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 HR Solutions, complete and sign a claim form, and provide proof of death to MetLife (see the Claims Procedures section of this Appendix). 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.

ADDITIONAL TAX CONSEQUENCES INFORMATION

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 Company-Paid Life Insurance in excess of $50,000 be reported as U.S. federal taxable income ("imputed income"). This imputed income will be reported on your Form W-2 in addition to your other U.S. federal taxable income. The imputed income is determined based on a Uniform Premium Table established by the U.S. federal government.

If your Company-Paid Life coverage exceeds $50,000, and you want to decrease the amount of your coverage to $50,000, you may elect to do so by contacting HR Solutions. Once coverage is reduced, it may not be reinstated.

The Company offers Employee-Paid Optional Life Insurance so that you are able to access coverage at below-market rates. If you have this coverage, the difference between the fair-market value and the amount you pay (when combined with Company-Paid Life insurance) is reported as taxable income to you (if it exceeds $50,000).

The Company offers Dependent Life Insurance so that you are able to access coverage at below-market rates. If you elect Spouse Dependent Life coverage, the difference between the fair-market value and the amount you pay is reported as taxable income to you.

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

The U.S. tax consequences of Company-Paid Life Insurance coverage are briefly described above. Employee-paid premiums are made on an after-tax basis. In general, life insurance proceeds are not subject to U.S. federal income tax. However, neither the Plan, nor the Company or any Participating Employer makes any assertion or warranty about the tax treatment of Plan coverage

or benefits under any taxing authority or jurisdiction, including U.S., non-U.S., state or local tax jurisdictions. The Participant or beneficiary, as applicable, shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

BENEFICIARIES

The preferred method for updating your beneficiaries is through the Dow U.S. Benefits Site. The Dow U.S. Benefits Site is at https://dowbenefits.ehr.com, and then click on "Change My Beneficiaries".

You may also 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. Note: You should submit the appropriate form to MetLife even if you submitted one to Dow previously.

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, or need to register for the first time, you can do so through the MetLife website (http://mybenefits.metlife.com) or through the Dow U.S. Benefits Site (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, from 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 designated beneficiary is a person other than a trustee and you and your designated beneficiary die under circumstances in which it is not clear who died first, the designated beneficiary will be deemed to have predeceased you.

If you were participating in the DCC Life Plan on December 31, 2016, your beneficiary designation was transferred to MetLife. You are encouraged to review your beneficiary designation as described above.

If you became an Employee of a Participating Employer as part of the separation of Dow Inc. from DowDuPont Inc., your beneficiary designation was not transferred to MetLife. You must make a beneficiary designation as described above.

If you were participating in the Nordben Plan (see "Coverage for Outbound Employees" on page 22, above) on September 30, 2017, your beneficiary designation was not transferred to MetLife. You must make a beneficiary designation as described above.

RECEIVING BENEFIT PAYMENTS

In the event of your death, your beneficiary should contact HR Solutions. 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 Claims Procedures in this Appendix. 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 HR Solutions at (833) 693-6947.

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 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 of $250. Your beneficiary may withdraw the entire balance immediately or at any time. Accountholders have the ability to link the TCA to all popular mobile payment apps and services. Also, accountholders can set up automatic debits that are deducted directly from the account. The TCA account holder will receive statements showing the account balance, drafts and ACH transactions that have cleared the account 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 Total Control Account. The performance results of any investments that MetLife makes with the TCA do not affect the interest rate MetLife pays to your beneficiary.

ADDITIONAL FUNDING INFORMATION

The Plan is funded by an insurance policy underwritten by MetLife. Dow pays the entire premium for Plan coverage. MetLife pays the benefits under the insurance policy.

Dow pays the entire premium for Plan coverage. Benefits are funded through a group insurance contract with MetLife. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from the assets of the Plan, if any.

ACCELERATED BENEFIT OPTION (ABO)

Under the Accelerated Benefit Option ("ABO"), if you have been diagnosed as terminally ill with 12 months or less to live, you may be eligible to receive up to 80% of your Company-Paid Life Insurance and Employee-Paid Life Insurance benefits before your death if certain requirements are met. For Texas residents, the requirement is 24 months or less to live. In order to apply for the ABO, you must be covered for at least $10,000 from your Company-Paid Life Insurance and/or Employee-Paid Life Insurance. You may receive an accelerated benefit of up to 80% (up to a maximum of $500,000) of your Company-Paid Life Insurance benefit, Employee-Paid Life Insurance benefit, or both. 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 Employee-Paid 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 taxes 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 the Company or any Participating Employer 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. 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 HR Solutions at (833) 693-6947 and must be completed and returned for evaluation and approval by MetLife. This benefit does not and is not intended to qualify as long-term care, including under Washington state law.

FUNERAL PLANNING AND DISCOUNTS

With your Company-Paid 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.

GRIEF COUNSELING

Your Company-Paid Life coverage comes with Grief Counseling at no extra cost, provided by LifeWorks US, Inc. ("LifeWorks"). 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. 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: metlifeassist; password: support) to contact a counselor or access helpful grief-related information and resources.

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 service 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 Company-Paid Life 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 any Participating Employer makes any assertion or warranty about the qualifications of or advice provided by legal or financial professionals.

ADDITIONAL ASSIGNMENT INFORMATION

You may make an assignment, or legal transfer, of the ownership of your Company-Paid or Employee-Paid 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.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for a Plan Benefit

The Initial Claims Reviewer and the Appeals Administrator are MetLife.

How to File a Claim for Life Insurance Benefits

For Claims for Plan Benefits, the claimant must call HR Solutions at (833) 693-6947 to report the death. (Retirees should call the Dow Retiree Service Center at (800) 344-0661 to report the death.) Dow will contact MetLife on your behalf and the beneficiary(ies) 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 can mail 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 not later than twelve months, after the date of death.

ADDITIONAL DEFINITIONS

"Actively at Work" or "Active Work" means that you are performing all of the usual and customary duties of your job with the Participating Employer on a Full Time or Less-Than Full Time basis. This must be done at:

- the Participating Employer's place of business; or;
- an alternate place approved by the Participating Employer; or
- a place to which the Participating Employer's business requires you to travel.

You will be deemed to be Actively at Work during weekends or Participating Employer-approved vacations, holidays or business closures if you were Actively at Work on the last scheduled work day preceding such time off.

"Administrator" means either the Plan Administrator or the Claims Administrator.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for 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 Section 18.

"Code" means the Internal Revenue Code of 1986, as amended.

"DCC Life Plan" means the Dow Corning Life and ADD Insurance Plan (ERISA Plan #503), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"DCC LTD Plan" means the Dow Corning Long Term Disability Plan (ERISA Plan #505), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"Dow LTD Program" means either The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008) (including the Dow AgroSciences Long Term Disability Insurance Program) or The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Are Actively at Work on or After January 1, 2008).

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

"Hourly Employee" means an Employee who is represented by a collective bargaining unit that is recognized by the Company or Participating Employer. "Bargained-for Employee" and "Hourly Employee" have the same meaning.

"Initial Claims Reviewer" means, 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 Section 18.

"MetLife" means Metropolitan Life Insurance Company.

"Retire" or "Retirement" means when an active Employee who meets the definition of a "Retiree" terminates employment with a Participating Employer.

"Retiree" means one of the following:

- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) is eligible to receive a pension under the Dow Employees' Pension Plan, and (3) was a Participant in the Program on the day preceding Retirement.
- An Employee who is receiving, or has received, a benefit under the 1993 Special Separation Payment Plan and who is 50 or older at the time they leave active employment with Dow, regardless of years of Service.
- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) terminated employment with Union Carbide Corporation or a subsidiary of Union Carbide Corporation that is a Participating Employer on or after February 6, 2003, (3) is eligible to receive a pension under the terms of the Union Carbide Employees'

Pension Plan, and (4) was a Participant in the Program on the day preceding termination of employment with the Participating Employer.

- An Employee who was divested to Olin Corporation on October 5, 2015, and was within six calendar months of becoming eligible for coverage under The Dow Chemical Company Retiree Company-Paid Life Insurance Plan on that date.
- On and after January 1, 2017, a former Employee of Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) who was a participant in the DCC Life Plan on December 31, 2016 as (1) a member of the "closed group of grandfathered retirees who retired prior to 1993" or (2) an "other eligible retired employee" who retired on or before December 31, 2016. For this purpose, "closed group of grandfathered retirees who retired prior to 1993" and "other eligible retired employee" shall have the meanings given to those terms under the DCC Life Plan.
- On and after January 1, 2017, an Employee who (1) was hired by Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) before January 1, 2006, (2) terminated employment with a Participating Employer after December 31, 2016, and (3) satisfies the requirements of the first bullet point above.

"Service" with respect to an Employee or a Retiree who is eligible to receive a pension from the Dow Employees' Pension Plan, means either "Eligibility Service" or "Credited Service" recognized under the Dow Employees' Pension Plan, whichever is greater. With respect to an Employee or a Retiree who is eligible to receive a pension from the Union Carbide Employees' Pension Plan, "Service" means "Eligibility Service" or "Credited Service" recognized under the Union Carbide Employees' Pension Plan, whichever is greater. For Employees of the Dow Mid-Michigan Business Process Service Center ("BPSC") and Business Services, LLC, "Service" is "Eligibility Service" as defined in the Dow Employees' Pension Plan determined as if the Dow Employees' Pension Plan recognized service for BPSC or Business Services, LLC. For purposes of the last bullet of the definition of Retiree and for purposes of satisfying the eligibility requirements for Company-Paid Life Insurance or Employee-Paid Life Insurance for certain disabled persons, Service shall include (1) "Credited Service" as defined in section 5.1(f) of Appendix J of the Dow Employees' Pension Plan ("Appendix J"), excluding service with other employers described in section 5.1(f)(ii) of Appendix J, and (2) service with Site Services, Inc. Refer to the Plan Document for the applicable Program for details.

23.2 Life Insurance 2

Former SPD Name:	The Dow Chemical Company Company-Paid Life Insurance Plan, Employee-Paid Life Insurance Plan, Dependent Life Insurance Plan
Legal Plan Name:	Employee-Paid And Dependent Life Insurance Plans
Legal Plan Number:	Plan 515
Claims Administrators 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

EMPLOYEE PAID LIFE INSURANCE

ADDITIONAL ELIGIBILITY INFORMATION

Salaried Employees

Salaried Employees of a Participating Employer who have regular, active, Full-Time, or Less-Than-Full-Time status, or are receiving partial disability payments under the Dow LTD Program are eligible for Plan coverage.

Hourly Employees

Eligibility of Hourly Employees depends on whether the applicable collective bargaining unit and the Participating Employer have agreed to this Plan. If the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Plan, then the terms of such collective bargaining agreement shall govern. If the terms of the collective bargaining agreement specify that Hourly Employees shall be provided this Plan, but do not specifically address the category of Employees that are eligible or not eligible, then regular, active Employees with Full Time status and Employees receiving partial disability payments under the Dow LTD Program who are members of the collective bargaining unit are eligible for coverage under the Plan.

Employees on a Leave of Absence

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by a Participating Employer, such as an approved leave of absence under the Company's Military Leave Policy, Family Leave Policy, or Medical Leave Policy, unpaid leave policy, or period during

which you receive partial disability payments under the Dow LTD Program. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. You must continue making any required contributions in order to keep your coverage in effect. The contributions must be paid by payroll deduction (if available) or any other means the Plan Administrator deems appropriate or necessary to collect the contributions. See the Employee Contribution section of this Appendix. For more details on benefits continuation during an approved leave of absence, please refer to the HR Portal KnowledgeBase articles on benefits during various leaves of absence, which are incorporated into the Plan and this SPD by reference.

Disabled Employees

If you are being paid a benefit from the Dow LTD Program or the DCC LTD Plan, you may be eligible under the Plan. See the Special Employee Paid Coverage for Certain Disabled Persons section of this Appendix.

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for the same amount of supplemental or employee-paid coverage you had immediately prior to your disability, until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. You must continue making any required contributions in order to keep your coverage in effect. See the Special Employee Paid Coverage for Certain Disabled Persons section of this Appendix.

Eligibility Determinations

The Claims Administrator for Claims for an Eligibility Determination determines eligibility to participate in the Plan. The Claims Administrator is a Plan fiduciary and has full discretion to interpret the provisions of the Plan and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants (except to the extent that determinations by the Initial Claims Reviewer are subject to review by the Appeals Administrator).

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan or have been told that you are not, you must follow the procedures described in the Claims Procedures in Section 18.

ADDITIONAL ENROLLMENT INFORMATION

To obtain Employee-Paid Life Insurance, you must enroll for coverage. If you wish to increase your current coverage, go to the Dow U.S. Benefits Site (http://dowbenefits.ehr.com). If you wish to decrease your coverage or if you do not have internet access, contact HR Solutions for assistance.

You may enroll:

- When you first become eligible:
    - Within 31 days of your first day of active employment, in which case coverage begins on your first day of active employment if you

provide a copy of your birth certificate or other proof of your age that the Plan Administrator deems appropriate. If you do not provide proof of your age that is satisfactory to the Plan Administrator within the time required by the Plan Administrator, you will not be covered.

  - Within 90 days of your first day of active employment, in which case coverage begins on your enrollment date if you provide a copy of your birth certificate or other proof of your age that the Plan Administrator deems appropriate. If you do not provide proof of your age that is satisfactory to the Plan Administrator within the time required by the Plan Administrator, you will not be covered.

- Following a Change-in-Status (described below under "Change-in-Status"), provided that you are Actively at Work and you provide proof of Change-in-Status and proof of age that are satisfactory to the Plan Administrator. Coverage will become effective as follows:
  - If the required proofs are received by the Plan Administrator within 31 days of the Change-in-Status, the change will become effective as of the date of the event.
  - If the required proofs are received by the Plan Administrator between 32 days to 90 days after the Change-in-Status, the change will become effective on the date that the Plan receives your enrollment or you enroll by calling HR Solutions.

If you do not provide the required proofs satisfactory to the Plan Administrator within the time required by the Plan Administrator, you will not be covered.

- During the open enrollment period, provided that you are Actively at Work on the January 1 following the open enrollment period. During open enrollment, you will be allowed to increase your coverage only by 1 increment (one-half times (1/2x) base annual salary) without providing a statement of health. A statement of health is required for coverage increases greater than 1 increment. If you submit an enrollment request for an increase of more than 1 increment, your enrollment will be accepted for the 1 increment increase, but any further increase will be subject to providing the statement of health. If you are not Actively at Work on the January 1 following the open enrollment period, any increase to your life insurance will not be effective until you return to Active Work.
- At any other time you are Actively at Work, if you provide a valid statement of health (available on the Dow U.S. Benefits Site (http://dowbenefits.ehr.com)). If you do not have internet access, you can obtain a statement of health form from MetLife's Statement of Health Unit at (800)638-6420. MetLife will pay for the fee of a paramedical exam, if requested by MetLife, with no cost to the employee/applicant when a MetLife physician is used.

Failure to provide the required proofs will result in cancellation of coverage, including retroactive cancellation, and may require you to reimburse the Plan for any benefits paid by the Plan. The Plan Administrator may request proof of your age at any time.

If you were an active Employee of Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) on December 31, 2016, and you failed to waive coverage or elect a lower level of coverage within the time period specified in the annual enrollment brochure for the 2017 Plan Year, you were enrolled in the same level of coverage you had under the DCC Life Plan (up to a maximum of $1.5 million) for the 2017 Plan Year. You may change your coverage as explained above.

If you became an Employee of a Participating Employer in April 2019, as part of the separation of Dow Inc. from DowDuPont Inc., you were enrolled in the closest level of coverage to what you had at DowDuPont Inc. You had 31 days from your start date to change your coverage.

CHANGE-IN-STATUS

A “Change-in-Status” is an event listed in one of the bullets below:

- An event that changes your legal marital status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner, divorce or annulment or similar event with respect to a Domestic Partnership.
- Birth, adoption, placement for adoption or death of Dependent.
- A termination or commencement of employment by you, your Spouse/Domestic Partner or Dependent.
- A reduction or increase in hours of employment by you, your Spouse/Domestic Partner or Dependent.
- Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents.

EMPLOYEE CONTRIBUTION

You pay the cost of Plan coverage through post-tax payroll deductions. Current rates are listed in your open enrollment materials. These costs are reviewed and revised periodically.

Your contribution is based on your age and whether you are a “non-tobacco-user.” As your age and salary change, your deductions will automatically be adjusted. You are considered a “non-tobacco-user” by the Plan if you have not used a tobacco product in the last 12 months or if you commit to completing a tobacco cessation program. If you quit using tobacco, you are considered a “non-tobacco-user” as of the first day of the month after you complete 12 non-tobacco-using months. If you commit to completing a tobacco cessation program within a year of your enrollment window, you are considered a “non-tobacco-user” for the period in which you are enrolling. If you are a tobacco user, you are considered a tobacco user as of the first day you use tobacco. Administratively, your premium deductions will not be adjusted until the first of the year following your change in tobacco user status. You must notify HR Solutions of any changes in your tobacco use, including your commitment to complete a tobacco cessation program. A false or out-of-date statement regarding tobacco use may result in benefits not being paid.

If you are on a leave of absence approved by the Participating Employer that provides eligibility under this Plan, the Plan Administrator has full discretion to make special administrative arrangements as are necessary to collect premiums, such as deferring Employee contributions on a temporary basis during the leave of absence, and requiring the Employee to repay premiums when the Employee returns to work, or any other arrangements the Plan Administrator deems appropriate.

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

COVERAGE DETAIL

Amount of Coverage

The amount of coverage is based on your annual pay:

- For Salaried employees, Inbound Employees, and Outbound Employees, base annual salary is used to calculate the life insurance amount.
- For Bargained-for employees, annual pay is calculated using your base hourly rate. For Deer Park Bargained-for employees who receive a Department Relief Operations (DRO) premium, the DRO premium is added to base hourly rate in the annual pay calculation.

Coverage for Salaried Employees, and for Hourly Employees of Applicable Collective Bargaining Units (Not Applicable If Receiving Payments for Full Disability or Total Disability under the Dow LTD Program)

The maximum amount of coverage available is $1.5 million.

Coverage for Salaried Employees and for Hourly Employees Whose Collective Bargaining Unit Has Agreed to this Plan

You may purchase coverage in increments equal to one-half times (1/2x) your annual pay, rounded up to the next $1,000. The maximum coverage allowable is equal to the lesser of (1) eight times (8x) your annual pay, or (2) $1.5 million.

If you waive the additional 1x coverage, you are not eligible to enroll for such coverage in the future.

Your coverage is automatically adjusted as your base salary changes, provided you are Actively at Work. If you are Less-Than-Full-Time, your coverage is based on your Full-Time base annual salary. Whether you are Full-Time or Less-Than-Full-Time, if you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

Special Employee Paid Coverage for Certain Disabled Persons

Dow LTD Program

If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan and you have been approved to receive benefit payments from the Dow LTD Program, you are eligible for Plan coverage under the following circumstances:

- If your date of "full disability" (as defined under the Dow LTD Program) is on or after January 1, 2006, you are eligible for coverage when your LTD benefit payments begin. The following applies to you:
    - If you were hired by Dow or Union Carbide on or after January 1, 2008, or you have less than ten (10) years of Service under the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, you are eligible for up to either 12 months or 24 months of Employee-Paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service, but less than ten (10) years of Service.
    - If you were hired by Dow or Union Carbide prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), and you have ten (10) or more years of Service, you are eligible for coverage until you are no longer eligible to receive payments from the Dow LTD Program. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.
    - If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of Employee-Paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service, but less than ten (10) years of Service
    - If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were hired prior to January 1, 2003, and you have ten (10) or more years of Service, you are eligible for coverage until you are no longer eligible to receive payments from the Dow LTD Program.

  - o The amount of coverage depends on the amount of coverage you had on the date you were last Actively at Work. If you had 1/2x, then the coverage amount is 1/2x. If you had 1x or more, then the amount is limited to 1x. You will be required to pay the same premiums active employees pay.

- If your date of "full disability" (as defined under the Dow LTD Program) is prior to January 1, 2006, the following applies to you:
  - o Refer to the explanation under Special Coverage for Certain Disabled Persons in this Appendix.
- If you are "partially disabled" (as defined under the Dow LTD Program), the following applies to you:
  - o You are eligible to purchase Plan coverage as described above under Coverage for Salaried Employees, and for Hourly Employees of Applicable Collective Bargaining Units (Not Applicable If Receiving Payments for Full Disability or Total Disability under the Dow LTD Program). Your base annual salary will be determined as if you were still working your pre-disability schedule. You must continue making any required contributions in order to keep your coverage in effect. If your paycheck is not large enough to cover your entire premium, your Participating Employer will bill you directly.

Rohm and Haas Company Long Term Disability Participants

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for the same amount of supplemental or employee-paid life insurance coverage you had immediately prior to your disability, if (1) your qualifying disability was incurred prior to January 1, 2010, and (2) you continue to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. Such coverage continues until you are no longer eligible to receive disability payments from that Program. You must continue making any required contributions in order to keep your coverage in effect.

DCC LTD plan

Certain disabled individuals of DCC are eligible to continue participating in the life insurance program. In general, to the extent that you are eligible for life insurance coverage as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as an Employee of Dow, unless otherwise stated.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.

- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for life insurance coverage until you are no longer eligible to receive payments from LTD.

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2017:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for life insurance coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).

You will be considered "retired" and thus ineligible for the Program as a DCC LTD Participant as follows:

Age Became Disabled	Date Considered "Retired"
Less than 60	Date reach age 65
60-64	Date that is 5 years after received first payment under the DCC LTD Plan
65-68	Date reach age 70
69 or older	Date that is 12 months after received first payment under the DCC LTD Plan

If you were disabled under the DCC LTD Plan on December 31, 2016, and you failed to waive coverage or elect a lower level of coverage within the time period specified in the annual enrollment brochure for the 2017 Plan Year, you were enrolled in the same level of coverage you had under the DCC Life Plan for the 2017 Plan Year (up to a maximum of $1.5 million). You may reduce coverage (as explained below) in increments of 1/2x your annual earnings. You may not increase coverage. Coverage ends the earlier of (1) the date you are no longer disabled under the DCC LTD Plan or (2) the date you reach age 65.

Increasing or Decreasing Coverage

You may increase the amount of your coverage (but not beyond the maximum amount for which you are eligible), unless you were disabled under the DCC LTD Plan on December 31, 2016, in which case you may only decrease, but not increase coverage:

- Within 90 days of a Change-in-Status event, such as Marriage, Domestic Partnership, a change in your Spouse's/Domestic Partner's employment, or the

addition of a Dependent child; provided that you are Actively at Work and HR Solutions receives satisfactory proof of Change-in-Status. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan.

- During open enrollment, if you are Actively at Work, you may increase one increment (1/2x) without completing and submitting a statement of health. A statement of health is required for coverage increases greater than 1 increment.
- At any other time you are Actively at Work, if you provide a valid statement of health (available on the Dow U.S. Benefits Site (http://dowbenefits.ehr.com)). If you do not have internet access, you can obtain a statement of health form from MetLife's Statement of Health Unit at (800) 638-6420. MetLife will pay for the fee of a paramedical exam, if requested by MetLife, with no cost to the employee/applicant when a MetLife physician is used.

You may decrease the amount of your coverage at any time by contacting HR Solutions.

Effective Dates of Coverage

<u>Beginning</u>

Your coverage generally begins on your date of enrollment and when you meet the enrollment requirements outlined in this booklet. Your coverage automatically is adjusted as your base salary changes. If you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

<u>Ending</u>

Your Employee-Paid Life Insurance coverage ends on the earliest of:

- the date the group policy ends;
- the date the Plan terminates;
- the date you no longer meet the eligibility requirements of the Plan;
- the end of the period for which your last premium has been paid; or
- the date your employment ends.

PORTING COVERAGE TO A SEPARATE GROUP TERM LIFE POLICY

If your Employee-Paid Life Insurance coverage under the Plan ends or is reduced because:

- You become retired or your employment ends; or
- You cease to be in a class that is eligible for this coverage; or
- Dow cancels the MetLife group life insurance policy or amends the Plan to exclude or change the amount of coverage for your work group; then the amount of coverage you lost may be continued on a direct bill basis with MetLife through the portability feature. Portability allows (former) employees 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 active 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 in any combination of Company-Paid Life Insurance and Employee-Paid Life Insurance. However, if your Employee-Paid Life Insurance coverage under the Plan ends because Dow has cancelled the Employee-Paid Life Insurance coverage under the MetLife group life insurance policy or because Dow has amended the Plan to exclude coverage for your work group, the maximum amount you may port is limited to the lesser of:

- the amount of your Employee-Paid Life Insurance and Company-Paid 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 (Barnum Financial Group) to offer you advice on the options available to you. You may receive a call from a local, specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor any Participating Employer 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.

CONVERTING TO AN INDIVIDUAL NON-TERM LIFE POLICY

If your Employee-Paid Life Insurance coverage under the Plan is reduced due to retirement, the amount of coverage you lost 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 Employee-Paid Life Insurance you lost under the Plan.

If your Employee-Paid Life Insurance coverage under the Plan ends because your employment ends, your 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 Employee-Paid Life Insurance in effect for you under the Plan on the date your employment ends.

If your Employee-Paid Life Insurance coverage ends because Dow has cancelled the Employee-Paid Life Insurance coverage under the MetLife group life insurance policy, or Dow has amended the Plan to exclude coverage for your work group, you may convert your Employee-Paid 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 Employee-Paid 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 Dow 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 (Barnum Financial Group) to offer you advice on the options available to you. You may receive a call from a local, specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor any Participating Employer 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 HR Solutions, complete and sign a claim form, and provide proof of death to MetLife (see Claims Procedures in this Appendix). 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.

BENEFICIARIES

The preferred method for updating your beneficiaries is through the Dow U.S. Benefits Site. The Dow U.S. Benefits Site is at https://dowbenefits.ehr.com, and then click on "Change My Beneficiaries".

You may also 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. Note: You should submit the appropriate form to MetLife even if you submitted one to Dow before March 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, or need to register for the first time, you can do so through the MetLife website (http://mybenefits.metlife.com) or through the Dow U.S. Benefits Site (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, from 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 designated beneficiary is a person other than a trustee and you and your designated beneficiary die under circumstances in which it is not clear who died first, the designated beneficiary will be deemed to have predeceased you.

If you were participating in the DCC Life Plan on December 31, 2016, your beneficiary designation was transferred to MetLife. You are encouraged to review your beneficiary designation as described above.

If you became an Employee of a Participating Employer as part of the separation of Dow Inc. from DowDuPont Inc., your beneficiary designation was not transferred to MetLife. You must make a beneficiary designation as described above.

RECEIVING BENEFIT PAYMENTS

In the event of your death, your beneficiary should contact HR Solutions. 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 Claims Procedures in this Appendix. 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 HR Solutions at (833) 693-6947.

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 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 of $250. Your beneficiary may withdraw the entire balance immediately or at any time. Accountholders have the ability to link the TCA to all popular mobile payment apps and services. Also, accountholders can set up automatic debits that are deducted directly from the account. The TCA account holder will receive statements showing the account balance, drafts and ACH transactions that have cleared the account 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 Total Control Account. The performance results of any investments that MetLife makes do not affect the interest rate MetLife pays to your beneficiary.

SUICIDE

This section is not applicable to residents of Washington. If you commit suicide within two years from the date your Employee-Paid Life Insurance takes effect, coverage under this Plan will not apply. For residents of Missouri and North Dakota, substitute "one year" for "two years" throughout this section called "Suicide." Any premium you paid for this coverage will be returned to your beneficiary.

If you commit suicide within two years from the date that an increase in your Employee-Paid Life Insurance takes effect, the coverage increase will not apply. Any premium you paid for the coverage increase will be returned to your beneficiary.

ADDITIONAL FUNDING INFORMATION

The Plan is funded by an insurance policy underwritten by MetLife. Employees pay the entire premium for Plan coverage. MetLife pays the benefits under the insurance policy.

Employees pay the premiums for Plan coverage. Benefits are funded through a group insurance contract with MetLife. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from the assets of the Plan, if any.

ACCELERATED BENEFIT OPTION (ABO)

Under the Accelerated Benefit Option ("ABO"), if you have been diagnosed as terminally ill with 12 months or less to live, you may be eligible to receive up to 80% of your Company-Paid Life Insurance and Employee-Paid Life Insurance benefits before your death if certain requirements are met. For Texas residents, the requirement is 24 months or less to live. In order to apply for the ABO, you must be covered for at least $10,000 from your Company-Paid Life Insurance and/or Employee-Paid Life Insurance. You may receive an accelerated benefit of up to 80% (up to a maximum of $500,000) of your Company-Paid Life Insurance benefit, Employee-Paid Life Insurance benefit, or both. 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 Employee-Paid 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 taxes 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 the Company or any Participating Employer 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. 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 HR Solutions at (833) 693-6947 and must be completed and returned for evaluation and approval by MetLife. This benefit does not and is not intended to qualify as long-term care, including under Washington state law.

WILL PREPARATION SERVICE

If you elect Employee-Paid Life Insurance coverage, you and your Spouse/Domestic Partner are eligible for a will preparation service available through MetLife Legal Plans, Inc. ("MetLife"). This service is available while your Employee-Paid Life Insurance coverage is in effect. The will preparation service is offered at no cost to you if you use an attorney designated by MetLife. If you have a will prepared by an attorney not designated by MetLife, you must pay for the attorney's services directly. You may receive a partial reimbursement for the amount you paid to the attorney if you provide proof of will service and payment satisfactory to MetLife. The amount reimbursable is the amount customarily reimbursed for such services by MetLife. Call (800) 821-6400 Monday through Friday from 8:00 a.m. to 7:00 p.m. ET for more information. A Client Services Representative will ask you to provide your Company Name and Group Number, which are:

- Company Name: The Dow Chemical Company
- Group Number: 11700-G

ESTATE RESOLUTION SERVICE

If you elect Employee-Paid Life Insurance coverage, you are eligible for an estate resolution service available through MetLife Legal Plans, Inc. ("MetLife"). This service is available if you or your Spouse/Domestic Partner die while your Employee-Paid Life Insurance coverage is in effect. The estate resolution service provides a MetLife in-network attorney to the executor/administrator probating your estate or that of your Spouse/Domestic Partner. Probate advice is also available to beneficiaries, regardless of whether they are the executor/administrator. This service is provided at no cost to the beneficiaries, administrator, executor, or estate if a MetLife in-network attorney is used.

The beneficiaries and/or executor/administrator may choose to use an attorney who does not participate in the MetLife network. If an out-of-network attorney is chosen, the beneficiary and/or executor/administrator must pay for that attorney's services directly. They may receive a partial reimbursement for the amount paid to the attorney if they provide proof of estate resolution service and payment satisfactory to MetLife. The amount reimbursable is the amount customarily reimbursed for such services by MetLife. To access this service, beneficiaries and/or executors/administrators should call MetLife at (800) 821-6400 Monday through Friday from 8:00 a.m.to 7:00 p.m. ET.

The following are not covered by this service: matters in which there is a conflict of interest between the executor, administrator, any beneficiary or heir and the estate; any disputes with the Company, Participating Employer, MetLife attorneys, MetLife and/or any of its affiliates; any

disputes involving statutory benefits (such as Social Security, unemployment, or workers' compensation benefits); will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

ADDITIONAL ASSIGNMENT INFORMATION

You may make an assignment, or legal transfer, of the ownership of your Company-Paid or Employee-Paid 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.

ADDITIONAL TAX CONSEQUENCES INFORMATION

The U.S. tax consequences of Company-Paid Life Insurance coverage are briefly described above. Employee-paid premiums are made on an after-tax basis. In general, life insurance proceeds are not subject to U.S. federal income tax. However, neither the Plan, nor the Company or any Participating Employer makes any assertion or warranty about the tax treatment of Plan coverage or benefits under any taxing authority or jurisdiction, including U.S., non-U.S., state or local tax jurisdictions. The Participant or beneficiary, as applicable, shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for a Plan Benefit

The Initial Claims Reviewer and the Appeals Administrator are MetLife.

How to File a Claim for Life Insurance Benefits

For Claims for Plan Benefits, the claimant must call HR Solutions at (833) 693-6947 to report the death. (Retirees should call the Dow Retiree Service Center at (800) 344-0661 to report the death.) Dow will contact MetLife on your behalf and the beneficiary(ies) 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 can mail 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 not later than twelve months, after the date of death.

ADDITIONAL DEFINITIONS

"Actively at Work" or "Active Work" means that you are performing all of the usual and customary duties of your job with the Participating Employer on a Full Time or Less-Than Full Time basis. This must be done at:

- the Participating Employer's place of business; or;
- an alternate place approved by the Participating Employer; or
- a place to which the Participating Employer's business requires you to travel.

You will be deemed to be Actively at Work during weekends or Participating Employer-approved vacations, holidays or business closures if you were Actively at Work on the last scheduled work day preceding such time off.

"Administrator" means either the Plan Administrator or the Claims Administrator.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for 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 Section 18.

"Code" means the Internal Revenue Code of 1986, as amended.

"DCC Life Plan" means the Dow Corning Life and ADD Insurance Plan (ERISA Plan #503), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"DCC LTD Plan" means the Dow Corning Long Term Disability Plan (ERISA Plan #505), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"Dow LTD Program" means either The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008)

(including the Dow AgroSciences Long Term Disability Insurance Program) or The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Are Actively at Work on or After January 1, 2008).

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

"Hourly Employee" means an Employee who is represented by a collective bargaining unit that is recognized by the Company or Participating Employer. "Bargained-for Employee" and "Hourly Employee" have the same meaning.

"Initial Claims Reviewer" means, 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 Section 18.

"MetLife" means Metropolitan Life Insurance Company.

"Retire" or "Retirement" means when an active Employee who meets the definition of a "Retiree" terminates employment with a Participating Employer.

"Retiree" means one of the following:

- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) is eligible to receive a pension under the Dow Employees' Pension Plan, and (3) was a Participant in the Program on the day preceding Retirement.
- An Employee who is receiving, or has received, a benefit under the 1993 Special Separation Payment Plan and who is 50 or older at the time they leave active employment with Dow, regardless of years of Service.
- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) terminated employment with Union Carbide Corporation or a subsidiary of Union Carbide Corporation that is a Participating Employer on or after February 6, 2003, (3) is eligible to receive a pension under the terms of the Union Carbide Employees' Pension Plan, and (4) was a Participant in the Program on the day preceding termination of employment with the Participating Employer.
- An Employee who was divested to Olin Corporation on October 5, 2015, and was within six calendar months of becoming eligible for coverage under The Dow Chemical Company Retiree Company-Paid Life Insurance Plan on that date.
- A former Employee of Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) who was a participant in the DCC Life Plan on December 31, 2016 as (1) a member of the "closed group of grandfathered retirees who retired prior to 1993" or (2) an "other eligible retired employee" who retired on or before December 31, 2016. For this purpose, "closed group of grandfathered retirees who

retired prior to 1993" and "other eligible retired employee" shall have the meanings given to those terms under the DCC Life Plan.

- An Employee who (1) was hired by Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) before January 1, 2006, (2) terminated employment with a Participating Employer after December 31, 2016, and (3) satisfies the requirements of the first bullet point above.

"Service" with respect to an Employee or a Retiree who is eligible to receive a pension from the Dow Employees' Pension Plan, means either "Eligibility Service" or "Credited Service" recognized under the Dow Employees' Pension Plan, whichever is greater. With respect to an Employee or a Retiree who is eligible to receive a pension from the Union Carbide Employees' Pension Plan, "Service" means "Eligibility Service" or "Credited Service" recognized under the Union Carbide Employees' Pension Plan, whichever is greater. For Employees of the Dow Mid-Michigan Business Process Service Center ("BPSC") and Business Services, LLC, "Service" is "Eligibility Service" as defined in the Dow Employees' Pension Plan determined as if the Dow Employees' Pension Plan recognized service for BPSC or Business Services, LLC. For purposes of the last bullet of the definition of Retiree and for purposes of satisfying the eligibility requirements for Company-Paid Life Insurance or Employee-Paid Life Insurance for certain disabled persons, Service shall include (1) "Credited Service" as defined in section 5.1(f) of Appendix J of the Dow Employees' Pension Plan ("Appendix J"), excluding service with other employers described in section 5.1(f)(ii) of Appendix J, and (2) service with Site Services, Inc. Refer to the Plan Document for the applicable Program for details.

DEPENDENT LIFE INSURANCE

ADDITIONAL ELIGIBILITY INFORMATION

Salaried Employees

Salaried Employees of a Participating Employer who have regular, active, Full-Time, or Less-Than-Full-Time status, or are receiving partial disability payments under the Dow LTD Program are eligible for Plan coverage.

Hourly Employees

Eligibility of Hourly Employees depends on whether the applicable collective bargaining unit and the Participating Employer have agreed to this Plan. If the terms of the applicable collective bargaining agreement specifically address which Employees are eligible or not eligible for the Plan, then the terms of such collective bargaining agreement shall govern. If the terms of the collective bargaining agreement specify that Hourly Employees shall be provided this Plan, but do not specifically address the category of Employees that are eligible or not eligible, then regular, active Employees with Full Time status and Employees receiving partial disability payments under the Dow LTD Program who are members of the collective bargaining unit are eligible for coverage under the Plan.

Employees on a Leave of Absence

Eligibility for benefits under the Plan may continue during certain leaves of absences approved by a Participating Employer, such as an approved leave of absence under the Company's Military Leave Policy, Family Leave Policy, or Medical Leave Policy, unpaid leave policy, or period during which you receive partial disability payments under the Dow LTD Program. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. You must continue making any required contributions in order to keep your coverage in effect. The contributions must be paid by payroll deduction (if available) or any other means the Plan Administrator deems appropriate or necessary to collect the contributions. See the Employee Contribution section of this Appendix. For more details on benefits continuation during an approved leave of absence, please refer to the HR Portal KnowledgeBase articles on benefits during leaves of absence, which are incorporated into the Plan and this SPD by reference.

Disabled Employees

If you are being paid a benefit from the Dow LTD Program or the DCC LTD Plan, you may be eligible under the Plan. See the Special Dependent Life Insurance Coverage for Certain Disabled Persons section of this Appendix.

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for the same amount of supplemental or employee-paid coverage you had immediately prior to your disability, until you are no longer eligible to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. You must continue making any required contributions in order to keep your coverage in effect. See the Special Dependent Life Insurance Coverage for Certain Disabled Persons section of this Appendix.

Eligibility Determinations

The Claims Administrator for Claims for an Eligibility Determination determines eligibility to participate in the Plan. The Claims Administrator is a Plan fiduciary and has full discretion to interpret the provisions of the Plan and to make findings of fact. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants (except to the extent that determinations by the Initial Claims Reviewer are subject to review by the Appeals Administrator).

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan or have been told that you are not, you must follow the procedures described in Section 18.

Dependent Eligibility

You may purchase coverage on the life of your Spouse/Domestic Partner and/or the life of your Dependent child or Dependent children.

In general, Dependent child means your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the

General Business

child of your Domestic Partner of Record); who, in each case, is under age 26, unmarried, and supported by you. For Texas residents, the term also includes your grandchild(ren), if they are able to be claimed by you as a dependent for federal income tax purposes. If you had dependent life insurance coverage under the DCC Life Plan for your grandchild(ren) on December 31, 2016, on and after January 1, 2017, Dependent child includes such grandchild(ren), on file with MetLife. Any such grandchild(ren) ceases to be eligible on the earlier of (1) the day that your child, who is the parent of such grandchild(ren), ceases to meet the eligibility requirements that otherwise apply to dependent children (e.g., the end of the month in which your child turns age 26); (2) the day that the grandchild(ren) ceases to meet the eligibility requirements that otherwise apply to dependent children (e.g., the end of the month in which the grandchild turns age 26); or (3) the effective date on which you cancel coverage under the Plan for the grandchild(ren). If you drop Dependent Life Insurance coverage under this Plan for such grandchild(ren) at any time and for any reason, you may not again enroll such grandchild(ren) in the Plan.

"Dependent child" does not include any person who is:

- insured under the group policy as an employee;
- covered as a dependent of another Dow Employee or Dow Retiree (all covered children in a family must be enrolled by the same parent); or
- age 26 years or older (coverage may continue until end of the month in which child attains age 26). A Dependent Spouse, Domestic Partner, or child is not eligible if they are in the military.

A Dependent child may be eligible for coverage past age 26 if the child continues to meet all of the requirements and in addition, is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law. Proof of such disability must be sent to MetLife within 31 days after the date the child attains the age limit and at reasonable intervals after such date.

ADDITIONAL ENROLLMENT INFORMATION

To obtain Dependent Life Insurance, you must enroll for coverage. If you wish to increase your current coverage, go to the Dow U.S. Benefits Site (http://dowbenefits.ehr.com). If you wish to decrease your coverage or if you do not have internet access, contact HR Solutions for assistance.

You may enroll:

- When you first become eligible:
    - Within 31 days of your first day of active employment, in which case coverage begins on your first day of active employment if you provide proof of Dependent eligibility and proof of age that the Plan Administrator deems appropriate. If you do not provide the required proofs within the time required by the Plan Administrator, your Dependent(s) will not be covered.
    - Within 90 days of your first day of active employment, in which case coverage begins on your enrollment date if you provide proof

of Dependent eligibility and proof of age that the Plan Administrator deems appropriate. If you do not provide the required proofs within the time required by the Plan Administrator, your Dependent(s) will not be covered.

- Following a Change-in-Status (described below under "Change-in-Status"), provided that you are Actively at Work and you provide proof of Change-in-Status and proof of age that are satisfactory to the Plan Administrator. Coverage will become effective as follows:
    - If the required proofs are received by the Plan Administrator within 31 days of the Change-in-Status, the change will become effective as of the date of the event.
    - If the required proofs are received by the Plan Administrator between 32 days to 90 days after the Change-in-Status, the change will become effective on the date that the Plan receives your enrollment or you enroll by calling HR Solutions.

Failure to provide the required proofs satisfactory to the Plan Administrator within the time required by the Plan Administrator will result in no coverage.

During the open enrollment period, provided that you are Actively at Work on the January 1 following the open enrollment period and you submit proof of eligibility prior to December 31 of the year before coverage begins. During open enrollment, you will be allowed to increase your Dependent Spouse/Domestic Partner coverage by one increment without providing a statement of health. A statement of health is required for Dependent Spouse/Domestic Partner coverage increases greater than 1 increment. If you submit an enrollment request for an increase of more than 1 increment, your enrollment will be accepted for the 1 increment increase, but any further increase will be subject to providing the statement of health. There is no incremental limit on increased coverage for Dependent child(ren) during open enrollment. If you are not Actively at Work on the January 1 following the open enrollment period, any increase in life insurance will not be effective until you return to Active Work.

At any other time you are Actively at Work, if you provide a valid statement of health (available on the Dow U.S. Benefits Site (http://dowbenefits.ehr.com)). If you do not have internet access, you can obtain a statement of health form from MetLife's Statement of Health Unit at (800) 638-6420. MetLife will pay for the fee of a paramedical exam, if requested by MetLife, with no cost to the employee/applicant when a MetLife physician is used. Your coverage begins on the date that MetLife approves your statement of health.

The Plan Administrator may request proof of Dependent eligibility and proof of age at any time. Proof may consist of a birth certificate, passport, adoption papers, marriage license, statement of Domestic Partnership or any other proof that the Plan Administrator deems appropriate. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims

for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan. Failure to provide proof of Dependent eligibility and proof of age within the time period required will result in no Dependent coverage.

If you enrolled for coverage for your Dependent(s) and fail to provide proof of Dependent eligibility or proof of age satisfactory to the Plan Administrator within the time period required, and the Plan determines that your Dependent(s) is not covered, the Plan reserves the right not to refund the premiums you paid, and to cancel coverage of your Dependent(s) retroactive to the date you enrolled your Dependent(s).

If you were an active Employee of Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) on December 31, 2016, and you failed to waive coverage or elect a different level of coverage within the time period specified in the annual enrollment brochure for the 2017 Plan Year, you were enrolled in the same level of coverage for the 2017 Plan Year that you had under the DCC Life Plan; provided that if you had coverage of $15,000 for Dependent child(ren), the coverage was reduced to $10,000. You may change your coverage as explained above.

If you became an Employee of a Participating Employer in April of 2019, as part of the separation of Dow Inc. from DowDuPont Inc., you were enrolled in the closest level of coverage to what you had at DowDuPont Inc. You had 31 days from your start date to change your coverage.

CHANGE-IN-STATUS

A “Change-in-Status” is an event listed in one of the bullets below:

- An event that changes your legal marital status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner, divorce or annulment or similar event with respect to a Domestic Partnership.
- Birth, adoption, placement for adoption or death of Dependent.
- A termination or commencement of employment by you, your Spouse/Domestic Partner or Dependent.
- A reduction or increase in hours of employment by you, your Spouse/Domestic Partner or Dependent.
- Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents.

EMPLOYEE CONTRIBUTION

You pay the cost of Plan coverage through post-tax payroll deductions. The cost is based on the coverage option that you choose. Current rates are listed in your open enrollment materials. These costs are reviewed and revised periodically.

For coverage on your Spouse/Domestic Partner’s life, your contribution will depend on whether your Spouse/Domestic Partner is a “non-tobacco-user.” Your Spouse/Domestic Partner is considered a “non-tobacco-user” by the Plan if they have not used a tobacco product in the last 12 months or if they commit to completing a tobacco cessation program. If your Spouse/Domestic

Partner quits using tobacco, they are considered a "non-tobacco-user" as of the first day of the month after they complete 12 non-tobacco-using months. If your Spouse/Domestic Partner commits to completing a tobacco cessation program within a year of your enrollment window, they are considered a "non-tobacco user" for the period in which you are enrolling . If your Spouse/Domestic Partner is a tobacco user, they are considered a tobacco user as of the first day they use tobacco. Administratively, your premium deductions will not be adjusted until the first of the year following your Spouse/Domestic Partner's change in tobacco user status. You must notify HR Solutions of any changes in your Spouse/Domestic Partner's tobacco use, including their commitment to complete a tobacco cessation program. A false or out-of-date statement regarding tobacco use may result in benefits not being paid.

If you are on a leave of absence approved by the Participating Employer that provides eligibility under this Plan, the Plan Administrator has full discretion to make special administrative arrangements as are necessary, such as deferring Employee contributions on a temporary basis during the leave of absence, and requiring the Employee to repay premiums when the Employee returns to work, or any other arrangements the Plan Administrator deems appropriate.

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

COVERAGE DETAIL

Amount of Coverage

Coverage for Salaried Employees and for Hourly Employees of Applicable Collective Bargaining Units (Not Applicable If Receiving Payments for Full Disability or Total Disability under the Dow LTD Program)

You may select coverage for your Spouse/Domestic Partner and Dependent children based on the following options:

- Spouse/Domestic Partner insurance coverage ranges from a minimum of $10,000 to a maximum of $250,000, in increments of $10,000. The monthly cost is based on your Spouse's/Domestic Partner's age, the amount of insurance, and whether your Spouse/Domestic Partner is a "non-tobacco-user."
- For eligible Dependent child(ren) there are four levels of coverage: $2,000, $5,000, $10,000, or $20,000.

Special Dependent Life Insurance Coverage for Certain Disabled Persons

If you are receiving benefit payments from The Dow Chemical Company Texas Operations Hourly Total and Permanent Disability Plan or The Dow Chemical Company Michigan Hourly Contract Disability Plan you are not eligible for Dependent Life Insurance coverage.

Dow LTD Program

If you have been approved to receive benefit payments from the Dow LTD Program, you are eligible for Dependent Life Insurance coverage under the following circumstances:

- If your date of "full disability" or "total disability" (as defined under the Dow LTD Program) is on or after January 1, 2018, the following applies to you:
    - If you were enrolled in Dependent Life Insurance coverage and had satisfied the Actively at Work requirement described under Enrollment, above, at the time of your "full disability" or "total disability" (as defined in the Dow LTD Program) and the disability occurred on or after January 1, 2018, you may continue your Dependent Life Insurance coverage. You must continue making any required contributions during your period of "full disability" or "partial disability."
- If you are "partially disabled" (as defined under the Dow LTD Program), the following applies to you:
    - If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you have been approved to receive a "partial disability" benefit (as defined under the Dow LTD Program), you may enroll or elect to continue Dependent Life Insurance coverage as described above under Coverage for Salaried Employees and for Hourly Employees of Applicable Collective Bargaining Units (Not Applicable If Receiving Payments for Full Disability or Total Disability under the Dow LTD Program). You must continue making any required contributions in order to keep your coverage in effect. If your paycheck is not large enough to cover your entire premium, your Participating Employer will bill you directly.

Rohm and Haas Company Long Term Disability Participants

If you have been approved for disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program, you are eligible for the same amount of dependent life insurance coverage you had immediately prior to your disability, if (1) your qualifying disability was incurred prior to January 1, 2010, and (2) you continue to receive disability payments under the Rohm and Haas Company Health and Welfare Plan's Long Term Disability Program. Such coverage continues until you are no longer eligible to receive disability payments from that Program. You must continue making any required contributions in order to keep your coverage in effect.

DCC LTD plan

If on or after January 1, 2018, you are receiving or have been approved to receive benefit payments from the DCC LTD Plan, you may purchase Dependent Life Insurance coverage as described above under Coverage for Salaried Employees and for Hourly Employees of

Applicable Collective Bargaining Units (Not Applicable If Receiving Payments for Full Disability or Total Disability under the Dow LTD Program). Such coverage continues until you are no longer eligible to receive disability payments from the DCC LTD Plan. You must continue making any required contributions in order to keep your coverage in effect.

Increasing or Decreasing Coverage

You may increase the amount of your coverage (but not beyond the maximum amount for which you are eligible):

- Within 90 days of a Change-in-Status event, such as Marriage, Domestic Partnership, a change in your Spouse's/Domestic Partner's employment, or the addition of a Dependent child; provided that you are Actively at Work and HR Solutions receives satisfactory proof of Change-in-Status.
- During open enrollment, if you are Actively at Work, you may increase one increment (1/2x) without completing and submitting a statement of health. A statement of health is required for coverage increases greater than 1 increment.
- At any other time you are Actively at Work, if you provide a valid statement of health (available on the Dow U.S. Benefits Site (http://dowbenefits.ehr.com)). If you do not have internet access, you can obtain a statement of health form from MetLife's Statement of Health Unit at (800) 638-6420. MetLife will pay for the fee of a paramedical exam, if requested by MetLife, with no cost to the employee/applicant when a MetLife physician is used.

You may decrease the amount of your coverage at any time by contacting HR Solutions.

Effective Dates of Coverage

Beginning

Your Dependent Life Insurance coverage generally begins on your date of enrollment and when you meet the enrollment requirements outlined in this booklet. If you are not Actively at Work, any increase to your life insurance will not be effective until you return to work.

Ending

Your Dependent Life Insurance coverage ends on the earliest of:

- the date the group policy ends;
- the date the Plan terminates;
- the date you or your Dependents no longer meet the eligibility requirements of the Plan;
- the end of the period for which your last premium has been paid; or
- the date your employment ends.

PORTING COVERAGE TO A SEPARATE GROUP TERM LIFE POLICY

If your Dependent Life Insurance coverage under the Plan ends or is reduced because:

- You become retired or your employment ends; or
- You cease to be in a class that is eligible for this coverage; or
- Dow cancels the MetLife group life insurance policy or amends the Plan to exclude or change the amount of coverage for your work group; or
- You die; or
- Your marriage ends in divorce or annulment; or
- Your Domestic Partnership ends; then
- the amount of coverage your Dependent loses may be continued on a direct bill basis with MetLife through the portability feature. If your former Dependent Spouse continues coverage for themself, then they may also use the portability feature to continue coverage for your Dependent child. If the insurance for your former Dependent child ends because they no longer meet the definition of "child" under the Dependent Life Insurance policy, your former Dependent child may also continue coverage with the portability feature. Portability allows Dependents 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 active plan rates, and a minimum of $2,500 for Spouse/Domestic Partner coverage ($10,000 when porting Spouse/Domestic Partner coverage alone) or $1,000 for Dependent child coverage must be ported to exercise this option.

If your Dependent Life Insurance coverage under the Plan ends because Dow has cancelled the Dependent Life Insurance coverage under the MetLife group life insurance policy or because Dow has amended the Plan to exclude coverage for your work group, the maximum amount you may port is limited to the lesser of:

- the amount of your life insurance or your Dependent Life Insurance coverage 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.

The application for portability must be submitted within 31 days from the date the Dependent Life Insurance coverage ends or is reduced. Your Dependent(s) may continue the same or a lesser amount of coverage (subject to the limits described above). If the entire life insurance amount is not continued through portability, the balance may be converted, as described immediately below.

You (or your Dependent(s), as applicable) 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 (Barnum Financial Group) to offer you advice on the options available

to you (or your Dependent). You may receive a call from a local, specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the Plan, the Company, nor any Participating Employer 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..

CONVERTING TO AN INDIVIDUAL NON-TERM LIFE POLICY

If your Dependent Life Insurance coverage under the Plan is reduced due to retirement, the amount of coverage your Spouse/Domestic Partner or Dependent child lost 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 Dependent Life Insurance lost under the Plan.

If your Dependent loses coverage under the Plan because of your death or because they no longer meet eligibility requirements, their coverage may be converted to an individual non-term policy through MetLife. (In the case of minor children, the parent or legal guardian may act on their behalf.) The maximum amount of insurance that may be elected for the new policy is the amount of Dependent Life Insurance that ends under the Dependent Life Insurance provisions of the MetLife group policy.

If your Dependent loses coverage under the Plan because Dow has cancelled the dependent life coverage under the group policy with MetLife, or Dow has amended the eligibility requirements of the Plan to exclude you or your dependents from eligibility under the Plan, you may convert coverage to an individual non-term MetLife policy for your Dependent; provided you have been enrolled in coverage for your Dependent under the Plan for at least 5 years immediately prior to the date the MetLife group coverage for your Dependent ended. The amount that may be converted is limited to the lesser of:

- the amount of Life Insurance for the Dependent that ends under the MetLife group policy, less the amount of life insurance for Dependents for which you become eligible under any group policy within 31 days after the date insurance ends under the Dependent Life Insurance provisions of the MetLife 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 Dow 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 (Barnum Financial Group) to offer you advice on the options available to you (or your Dependent). You may receive a call from a local, specially trained Barnum Financial Group financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives. Neither the

Plan, the Company, nor any Participating Employer 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 your Dependent dies within 31 days after the date life insurance for the Dependent ends or is reduced by an amount eligible for conversion, your Dependent's beneficiary should contact HR Solutions, complete and sign a claim form, and provide proof of death to MetLife (see Claims Procedures in this Appendix). MetLife will review the claim and, if the claim is approved, will pay your Dependent's beneficiary the amount that could have been converted. The amount that could have been converted will not be paid as insurance under both a new individual conversion policy and the group policy.

BENEFICIARIES

You are the beneficiary of your coverage under the Plan. This cannot be changed. The benefits will be paid to you if you survive the Dependent.

If you do not survive your Dependent, MetLife may pay the benefit to 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. Any payment made by MetLife in good faith will discharge the Plan's and MetLife's liability to the extent of such payment.

RECEIVING BENEFIT PAYMENTS

In the event of the death of your Spouse/Domestic Partner or Dependent child, contact HR Solutions. You 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 Claims Procedures in this Appendix. 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 the beneficiary requests payment by check. Contact HR Solutions at (833) 693-6947.

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 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 of $250. Your beneficiary may withdraw the entire balance immediately or at any time. Accountholders have the ability to link the TCA to all popular mobile payment apps and services. Also, accountholders can set up automatic debits that are deducted directly from the account. The TCA account holder will receive statements showing the account balance, drafts and ACH transactions that have cleared the account 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 Total Control Account. The performance results of any investments MetLife makes do not affect the interest rate MetLife pays to your beneficiary.

SUICIDE

This Section is not applicable to residents of Washington. If you or your covered spouse commit suicide within two years from the date your Employee-Paid Life Insurance or Dependent Life Insurance (as applicable) takes effect, coverage under this Plan will not apply. For residents of Missouri and North Dakota, substitute "one year" for "two years" throughout this section called "Suicide." Any premium you paid for this coverage will be returned to your beneficiary.

If you or your covered spouse commit suicide within two years from the date that an increase in your Employee-Paid Life Insurance or Dependent Life Insurance (as applicable) takes effect, the coverage increase will not apply. Any premium you paid for the coverage increase will be returned to your beneficiary.

For more information, please see your insurance certificate.

ADDITIONAL FUNDING INFORMATION

The Plan is funded by an insurance policy underwritten by MetLife. Employees pay the entire premium for Plan coverage. MetLife pays the benefits under the insurance policy.

Employees pay the premiums for Plan coverage. Benefits are funded through a group insurance contract with MetLife. Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from the assets of the Plan, if any.

ACCELERATED BENEFIT OPTION (ABO)

Under the Accelerated Benefit Option ("ABO"), if your Spouse/Domestic Partner has been diagnosed as terminally ill with 12 months or less to live, you may be eligible to receive up to 80% of your Spouse/Domestic Partner Dependent Life Insurance benefits before your Spouse/Domestic Partner's death if certain requirements are met. For Texas residents, the requirement is 24 months or less to live. In order to apply for the ABO, your Spouse/Domestic Partner must be covered for at least $10,000 under the Plan. You may receive an accelerated benefit of up to 80% (up to a maximum of $200,000) of the Spouse/Domestic Partner Dependent Life Insurance benefit. 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 your Spouse/Domestic Partner's Dependent 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 taxes 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 the Company or any Participating Employer 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. 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 HR Solutions at (833) 693-6947 and must be completed and returned for evaluation and approval by MetLife. This benefit does not and is not intended to qualify as long-term care, including under Washington state law.

ADDITIONAL ASSIGNMENT INFORMATION

You may make an assignment, or legal transfer, of the ownership of your Company-Paid or Employee-Paid 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.

ADDITIONAL TAX CONSEQUENCES INFORMATION

The U.S. tax consequences of Company-Paid Life Insurance coverage are briefly described in above. Employee-paid premiums are made on an after-tax basis. In general, life insurance proceeds

are not subject to U.S. federal income tax. However, neither the Plan, nor the Company or any Participating Employer makes any assertion or warranty about the tax treatment of Plan coverage or benefits under any taxing authority or jurisdiction, including U.S., non-U.S., state or local tax jurisdictions. The Participant or beneficiary, as applicable, shall bear any taxes on Plan benefits, regardless of whether taxes are withheld or withholding is required.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for a Plan Benefit

The Initial Claims Reviewer and the Appeals Administrator are MetLife.

How to File a Claim for Life Insurance Benefits

For Claims for Plan Benefits, the claimant must call HR Solutions at (833) 693-6947 to report the death. (Retirees should call the Dow Retiree Service Center at (800) 344-0661 to report the death.) Dow will contact MetLife on your behalf and the beneficiary(ies) 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 can mail 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 not later than twelve months, after the date of death.

ADDITIONAL DEFINITIONS

"Actively at Work" or "Active Work" means that you are performing all of the usual and customary duties of your job with the Participating Employer on a Full Time or Less-Than Full Time basis. This must be done at:

- the Participating Employer's place of business; or;
- an alternate place approved by the Participating Employer; or
- a place to which the Participating Employer's business requires you to travel.

You will be deemed to be Actively at Work during weekends or Participating Employer-approved vacations, holidays or business closures if you were Actively at Work on the last scheduled work day preceding such time off.

"Administrator" means either the Plan Administrator or the Claims Administrator.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for 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 Section 18.

"Code" means the Internal Revenue Code of 1986, as amended.

"DCC Life Plan" means the Dow Corning Life and ADD Insurance Plan (ERISA Plan #503), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"DCC LTD Plan" means the Dow Corning Long Term Disability Plan (ERISA Plan #505), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"Dow LTD Program" means either The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008) (including the Dow AgroSciences Long Term Disability Insurance Program) or The Dow Chemical Company Long Term Disability Insurance Program (Applicable to Those Who Are Actively at Work on or After January 1, 2008).

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

"Hourly Employee" means an Employee who is represented by a collective bargaining unit that is recognized by the Company or Participating Employer. "Bargained-for Employee" and "Hourly Employee" have the same meaning.

"Initial Claims Reviewer" means, 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 Section 18.

"MetLife" means Metropolitan Life Insurance Company.

"Retire" or "Retirement" means when an active Employee who meets the definition of a "Retiree" terminates employment with a Participating Employer.

"Retiree" means one of the following:

- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) is eligible to receive a pension under the Dow Employees' Pension Plan, and (3) was a Participant in the Program on the day preceding Retirement.
- An Employee who is receiving, or has received, a benefit under the 1993 Special Separation Payment Plan and who is 50 or older at the time they leave active employment with Dow, regardless of years of Service.
- An Employee who (1) is age 50 or older with 10 or more years of Service when their employment terminated with a Participating Employer, (2) terminated employment with Union Carbide Corporation or a subsidiary of Union Carbide Corporation that is a Participating Employer on or after February 6, 2003, (3) is eligible to receive a pension under the terms of the Union Carbide Employees' Pension Plan, and (4) was a Participant in the Program on the day preceding termination of employment with the Participating Employer.
- An Employee who was divested to Olin Corporation on October 5, 2015, and was within six calendar months of becoming eligible for coverage under The Dow Chemical Company Retiree Company-Paid Life Insurance Plan on that date.
- A former Employee of Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) who was a participant in the DCC Life Plan on December 31, 2016 as (1) a member of the "closed group of grandfathered retirees who retired prior to 1993" or (2) an "other eligible retired employee" who retired on or before December 31, 2016. For this purpose, "closed group of grandfathered retirees who retired prior to 1993" and "other eligible retired employee" shall have the meanings given to those terms under the DCC Life Plan.
- An Employee who (1) was hired by Dow Silicones Corporation (Dow Corning Corporation prior to February 1, 2018) before January 1, 2006, (2) terminated employment with a Participating Employer after December 31, 2016, and (3) satisfies the requirements of the first bullet point above.

"Service" with respect to an Employee or a Retiree who is eligible to receive a pension from the Dow Employees' Pension Plan, means either "Eligibility Service" or "Credited Service" recognized under the Dow Employees' Pension Plan, whichever is greater. With respect to an Employee or a Retiree who is eligible to receive a pension from the Union Carbide Employees' Pension Plan, "Service" means "Eligibility Service" or "Credited Service" recognized under the Union Carbide Employees' Pension Plan, whichever is greater. For Employees of the Dow Mid-Michigan Business Process Service Center ("BPSC") and Business Services, LLC, "Service" is "Eligibility Service" as defined in the Dow Employees' Pension Plan determined as if the Dow Employees' Pension Plan recognized service for BPSC or Business Services, LLC. For purposes of the last bullet of the definition of Retiree and for purposes of satisfying the eligibility requirements for Company-Paid Life Insurance or Employee-Paid Life Insurance for certain

disabled persons, Service shall include (1) “Credited Service” as defined in section 5.1(f) of Appendix J of the Dow Employees’ Pension Plan (“Appendix J”), excluding service with other employers described in section 5.1(f)(ii) of Appendix J, and (2) service with Site Services, Inc. Refer to the Plan Document for the applicable Program for details.

General Business

23.3 Life Insurance 3

Former SPD Name:	The Dow Chemical Company COLI Incentive Benefit Program
Legal Plan Name:	COLI Incentive Benefit Program
Legal Plan Number:	Plan 530
Claims Administrators for Claims for Plan Benefits:	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, MI 48674 Attention: Initial Claims Reviewer for the COLI Incentive Benefit Program

ADDITIONAL ELIGIBILITY INFORMATION

Any active Salaried Full-Time Employee or Retiree of The Dow Chemical Company and Participating Subsidiaries and Full Time active Midland Hourly Employees who have provided written consent to the Company to purchase Corporate-Owned Life Insurance ("COLI") on their lives in 1991 and 1992 is eligible. An Employee or Retiree eligible for or receiving a benefit under the Dow Employees' Pension Plan ("DEPP"), on whom the Company purchased COLI on their life in December 1983, November 1985, or May 1988, is also eligible.

EMPLOYEE CONTRIBUTION

Dow and/or its Participating Subsidiaries provide this benefit at no cost to you.

COVERAGE DETAIL

Amount of Coverage - Salaried

The amount of the benefit paid upon the death of a Salaried Employee or Retiree is as follows:

- $5,000 if at the time of your death, you are an active Salaried Full-Time or Less-Than-Full-Time Employee, a Salaried Retiree, or are receiving or have been approved to receive payment from The Dow Chemical Company Long Term Disability Program ("LTD Plan");
- $2,500 if you were a Salaried Employee who left Dow and/or a Participating Subsidiary prior to Retirement. In this case, the benefit is payable only to your surviving Spouse or surviving Domestic Partner; if you have no surviving Spouse or surviving Domestic Partner at the time of your death, no benefit will be paid.

For purposes of the Plan, an employee does not "leave Dow and/or its Participating Subsidiaries" when the employee leaves Dow or a Participating Subsidiary to immediately work for an entity that is partially owned, directly or indirectly, by The Dow Chemical Company. If at the time of your death, you previously left the Company or Participating Subsidiary prior to Retirement, but later were re-hired, then the $5,000 death benefit amount will apply if you meet the criteria in the first bullet point above.

Amount of Coverage - Midland Hourly

The amount of the benefit paid upon the death of a Midland Hourly Employee or Midland Hourly Retiree is as follows:

- $4,000 if, at the time of your death, you are a Full-Time active Midland Hourly Employee, a Midland Hourly Retiree, or are receiving or have been approved to receive payment from Dow's Michigan Division Contract Disability Program;
- $2,000 if you were a Midland Hourly Employee who previously left the Company prior to Retirement. In this case, the benefit is payable only to your surviving Spouse or surviving Domestic Partner; if you have no surviving Spouse or surviving Domestic Partner at the time of your death, no benefit will be paid.

For purposes of the Plan, an employee does not "leave Dow and/or its Participating Subsidiaries" when the employee leaves Dow or a Participating Subsidiary to immediately work for an entity that is partially owned, directly or indirectly, by The Dow Chemical Company.

EFFECTIVE DATES OF COVERAGE

Beginning

December 1, 1991 for Salaried Employees. February 1, 1992 for Midland Hourly Employees.

Ending

Your participation in the Plan ends once your beneficiary is paid the death benefit. Upon the death of an Employee who left Dow or Participating Subsidiary prior to Retirement, the death benefit will be paid to their surviving Spouse or surviving Domestic Partner. If there is no surviving Spouse or surviving Domestic Partner, no benefit will be paid, and the Plan will end for such Participant at time of death.

BENEFICIARIES

If you die while you are an active Employee, a Retiree under DEPP, or are receiving a payment from LTD or Contract Disability, the beneficiary is the same as the beneficiary on your Company-Paid Life Insurance, unless you specify in writing otherwise. You may elect a different beneficiary by completing and returning a beneficiary form to the HR Service Center.

If there is no beneficiary designation in effect, any Plan benefit will be paid to the your estate.

Notwithstanding the above, if you die after you left Dow or a Participating Subsidiary prior to Retirement, the benefit will be paid only to your surviving Spouse or surviving Domestic Partner; if you have no surviving Spouse or surviving Domestic Partner at the time of your death, no benefit will be paid.

ADDITIONAL FUNDING INFORMATION

Dow pays the entire cost of the Plan. Benefits are paid from Dow's general assets.

Section 24. Appendix B. Voluntary Accident Insurance Information

24.1 Voluntary Accident Insurance

Former SPD Name:	The Dow Chemical Company Voluntary Group Accident Insurance Plan
Legal Plan Name:	Voluntary Group Accident Insurance
Legal Plan Number:	Plan 504
Claims Administrators for Claims for Plan Benefits:	National Union Fire Insurance Company of Pittsburgh PA (NUFIC), an AIG company: NUFIC Accident and Health Claims Division P. O. Box 25987 Shawnee Mission, KS 66225-5987 1-800-551-0824

ADDITIONAL FUNDING INFORMATION

Employees pay the premiums for Plan coverage. Benefits under the Plan are insured through a group insurance contract with National Union Fire Insurance Company of Pittsburgh PA (NUFIC). Benefits, if any, that are not paid through a group insurance contract are paid from the Company's or Participating Employer's general assets.

Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from assets of the Plan, if any.

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

JOINT INSURANCE AGREEMENT

Dorinco Reinsurance Company ("Dorinco") and NUFIC have entered into an arrangement approved by the U.S. Department of Labor pursuant to Prohibited Transaction Exemption 85-108, Exemption Application No. D-6057, in which NUFIC has or will write the coverage for the Plan and Dorinco will assume a percentage of the risk. Dorinco is a subsidiary of the Company. Under the insurance arrangement between NUFIC and Dorinco, NUFIC and Dorinco will each be liable to pay the agreed upon percentage of each claim in respect of a Plan Participant. When a Claim for Plan Benefits is approved, Dorinco transfers its percentage of the claim to NUFIC, and NUFIC pays the full amount of the claim. If Dorinco is financially unable to pay its designated percentage of a particular claim, NUFIC is obligated to pay the entire amount of the

claim. Neither NUFIC nor Dorinco will charge the Plan any administrative fees, commissions, or other consideration as a result of the participation of Dorinco.

ADDITIONAL ELIGIBILITY INFORMATION

Employee Eligibility

Salaried Employees

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

Hourly Employees

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

Employees on a Leave of Absence

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

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

Family Eligibility

If you are enrolled for coverage in the Plan, then your Spouse/Domestic Partner is also eligible for Plan coverage, except that, if your Spouse/Domestic Partner is a Dow Employee, you may

not enroll your Spouse/Domestic Partner as a Dependent. Instead, your Spouse/Domestic Partner must enroll in the Plan separately as a Dow Employee.

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

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

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

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

Documentation of Dependent Eligibility

The Plan reserves the right, at any time, to request proof of Dependent eligibility, such as birth certificates, passports, Marriage certificates, Domestic Partner signed statements, or any other form of proof the Plan Administrator deems appropriate. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan. Failure to provide proof of eligibility within the time required will result in no coverage and/or will result in retroactive cancellation of coverage. If this occurs, you may be required to reimburse the plan for any Plan benefits the Plan has paid.

Corporate Pilots

Coverage includes all Employees classified as Corporate Pilots of Dow while they are performing, learning to perform, or instructing others to perform as a licensed pilot or crew member of an approved aircraft that is owned, leased, chartered or rented by Dow and is being operated at the time on Dow business.

Rohm and Haas Company Disability Participants

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

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

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

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

ADDITIONAL ENROLLMENT INFORMATION

Enrollment Process and Timing of Coverage

To obtain Plan coverage, enroll during the annual enrollment period or go to the Dow U.S. Benefits Site at www.dowbenefits.ehr.com. If you do not have internet access, HR Solutions can provide assistance. You may enroll:

- On or before your employment date, in which case coverage begins as of the later of the date your enrollment is received by the Plan Administrator or your first day at work.
- Within 90 days of your first day of active employment, in which case coverage begins as of the date that your enrollment is received by the Plan Administrator.
- Within 90 days of a change in your personal status (see below, regarding change in status).
- During the annual enrollment period, in which case coverage begins as of January 1st. If at annual enrollment you fail to enroll or affirmatively waive coverage under the Plan, your current Plan election will be automatically carried forward for the upcoming Plan Year, assuming you remain eligible.

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

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

Reduction of Certain Benefit Elections to Prevent Discrimination

The Plan Administrator has the authority to change the benefit elections of certain Participants if such a change is necessary to prevent the Plan from becoming discriminatory within the meaning of Section 125(b) of the Internal Revenue Code (the “Code”). If the Plan Administrator determines, or is informed by the plan administrator of The Dow Chemical Company Flexible Spending Plan (the “Flexible Spending Plan”), before or during any Plan Year, that the Flexible Spending Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to key employees or highly compensated employees (each as defined in Section 125 of the Code), the Plan Administrator will take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by key employees or highly compensated employees with or without the consent of such employees.

Change in Status

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

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

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

- An event that changes your legal marital/domestic partner status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner, divorce, annulment, or Termination of Domestic Partnership.
- An event that changes your number of Dependents, including birth, adoption, placement for adoption, or death of your Dependent Child.
- A termination or commencement of employment for you or your Spouse/ Domestic Partner or Dependent Child.
- A reduction or increase in hours of employment for you or your Spouse/ Domestic Partner or Dependent Child.
- Your Dependent Child satisfies or ceases to satisfy the definition for “Dependent Child.”

- Your Spouse/Domestic Partner gains eligibility for coverage under the Spouse/ Domestic Partner's employer's voluntary group accident plan.

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

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

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

Enrollment Deadline for Mid-Year Changes

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

Required Documentation

Documentation is required to show proof of eligibility to make an election change and/or to show proof of Dependent eligibility. Required documentation may include birth certificates, passports, Marriage certificates, Domestic Partner signed statements, Social Security numbers, a court order evidencing legal separation, evidence of loss of Spouse/Domestic Partner or Dependent's employment, or any other form of proof the Plan Administrator deems appropriate. The Plan reserves the right to, at anytime, request proof of eligibility. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan. Failure to provide proof of eligibility within the time required will result in no coverage and may result in retroactive cancellation of coverage. If this occurs, you may be required to reimburse the Plan for any payments for benefits already paid by the Plan. Additional or alternative actions might be taken on account of your or your Dependent's fraudulent actions or inactions or intentional misrepresentations. See below for more information on the consequences of fraud.

Ending Coverage

Coverage under the Plan ends when any of the following occurs:

- The Participant no longer meets the eligibility requirements
- The Employee elects not to participate for the Plan Year
- Date that required premiums are due but not paid
- Death
- The Employee Retires
- The Employee begins receiving benefits under The Dow Chemical Company Long Term Disability Program (Applicable to Those Actively at Work on or after January 1, 2008) (ERISA Plan #606)
- The Employee takes a leave of absence (other than certain leaves of absences described in the Appendices or the Plan Document and other unique situations specified in the Plan Document)
- The Employee terminates employment with Dow or the Participating Employer
- The date your employer ceases to be a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code
- Work stoppage

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

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

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

EMPLOYEE CONTRIBUTION

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

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

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

COVERAGE DETAIL

Coverage Amounts

INSURED PERSON	COVERAGE IN INCREMENTS OF	MINIMUM AMOUNT	MAXIMUM AMOUNT SPOUSE/DOMESTIC PARTNER
EMPLOYEE	$10,000	$10,000	$500,000
SPOUSE/DOMESTIC PARTNER OF EMPLOYEE	$10,000	$10,000	$250,000
ROHM & HAAS COMPANY DISABILITY PARTICIPANT*	$10,000	$10,000	$100,000
SPOUSE/DOMESTIC PARTNER OF ROHM & HAAS COMPANY DISABILITY PARTICIPANT*	$10,000	$10,000	$50,000

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

If you are insured under the Plan, your Dependent Child is covered under the Plan automatically. Only one benefit is payable per child, and the benefit is based on the parent insured for the greater amount of coverage. The amount of Dependent Child coverage is limited to:

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

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

Coverage Provisions

The amount of coverage you select is called the Principal Sum. If you, your insured Spouse/Domestic Partner or Dependent Child incur any of the following losses within 365 days of a Covered Accident, the Plan will pay a percentage of the Principal Sum as listed in the table below, provided that Spouses, Domestic Partners, and Dependent Children are not eligible for Plan benefits on account of permanent and total disability. Benefits are paid in U.S. dollars. If a benefit cannot be paid in U.S. dollars due to local laws, the benefit will be paid by the Participating Employer in local currency so as to comply with applicable law; provided that the Participant and/or the beneficiary, whichever is applicable, waives any and all of their rights to receive a benefit from the Plan or the insurance carrier. Such payment will be converted to local currency using the exchange rate in effect at the payor bank designated by the Participating Employer on the date the payment is issued to the beneficiary. By a separate agreement between the Plan Sponsor and the insurance carrier, the Participating Employer will then be reimbursed by the insurance company. The U.S. dollar amount is based on the percentage of Principal Sum payable and the annual base salary and currency exchange rate, determined as of the date of the Covered Accident. If you are on an expatriate assignment, the U.S. dollar amount is based on the percentage of Principal Sum payable, and the annual base salary in home-country currency and the currency exchange rate, determined as of the date of the Covered Accident. The home-country annual base salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

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

Table of Losses

	MAXIMUM PERCENTAGE OF PRINCIPAL SUM

LOSS OF:	
LIFE	**100%**
BOTH HANDS OR BOTH FEET	**100%**
TOTAL SIGHT OF BOTH EYES	**100%**
ONE HAND AND ONE FOOT	**100%**
ONE HAND AND THE TOTAL SIGHT OF ONE EYE	**100%**
ONE FOOT AND THE TOTAL SIGHT OF ONE EYE	**100%**
SPEECH AND HEARING IN BOTH EARS	**100%**
ONE HAND OR ONE FOOT	**50%**
TOTAL SIGHT OF ONE EYE	**50%**
SPEECH OR HEARING IN BOTH EARS	**50%**
HEARING IN ONE EAR	**25%**
THUMB AND INDEX FINGER OF THE SAME HAND	**25%**
PARALYSIS:	
QUADRIPLEGIA	**100%**
PARAPLEGIA	**50%**
HEMIPLEGIA	**50%**
UNIPLEGIA	**25%**
COMA	**1% per month for 100 months or until the coma ends, if earlier**
SEVERE BURN:	
FACE AND NECK AND HEAD	**99%**
HAND AND FOREARM BELOW ELBOW JOINT	**22.5%**

UPPER ARM BELOW SHOULDER JOINT TO ELBOW JOINT	**13.5%**
TORSO BELOW NECK TO SHOULDER JOINTS AND HIP JOINTS	**36%**
THIGH BELOW HIP JOINT TO KNEE JOINT	**9%**
FOOT AND LOWER LEG BELOW KNEE JOINT	**27%**
PERMANENT TOTAL DISABILITY	**100%**

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

Coma

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

Common Disaster

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

Conversion to Individual Policy

If you become ineligible for coverage under this Plan (prior to age 70), you may elect to convert the accidental death and dismemberment portion of your existing coverage to an individual policy. No evidence of insurability is required to obtain the individual policy. The converted insurance must be at least $100,000 and cannot exceed the greater of (1) the amount of your existing coverage; or (2) $500,000. If the accidental death and dismemberment portion of your

existing coverage is less than $100,000, you may elect to convert the coverage to an individual policy of $100,000. Coverage for your Spouse/Domestic Partner or Dependent Child may be converted only if they are the age of majority or over on the date the coverage ends. The insurance company must receive your application and premium payment within 31 days of losing eligibility in order to convert the insurance. Contact NUFIC's general agent (Reuben Warner Associates, telephone 800-421-3005) to obtain enrollment information.

Day Care

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

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

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

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

Education

<u>Dependent Child</u>

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

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

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

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

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

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

Spouse/Domestic Partner

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

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

Exclusions

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

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at self-inflicted injury;
- Sickness, disease, mental incapacity or bodily infirmity, whether the loss results directly or indirectly from any of these;
- Infections of any kind, regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning, or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition;

- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (The unearned premium for any period for which the Insured Person is not covered due to their active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);
- Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers, or performing, learning to perform, or instructing others to perform as a pilot or crew member in any aircraft, unless this is your Dow job function and in a Company-owned, leased, or operated aircraft or unless you are enrolled in the Recreational Pilot Insurance segment of this Plan (and comply with the terms thereof);
- Declared or undeclared war, or any act of declared or undeclared war, except to the extent provided in the Policy and summarized in this Appendix;
- The Insured Person's commission of or attempt to commit a felony; or
- The Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.

Exposure and Disappearance

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

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

Extension of Family Plan Coverage

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

In-Hospital

If you or your covered Spouse/Domestic Partner or Dependent Child is hospitalized for more than seven days as a result of a Covered Accident, and such hospitalization occurs within 365 days of that Covered Accident, the Plan will pay a monthly benefit equal to the lesser of $1,000 or one percent of the Principal Sum. Benefits will be paid retroactive to the first day of hospitalization and are payable for up to six consecutive months for any one Hospital confinement. (See definition of "Hospital" below in the Definition of Terms). This benefit is not

payable if the Insured Person is confined to a clinic, nursing, convalescent home or a rehabilitation facility for the treatment of alcoholism or substance abuse.

Multiple Losses

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

Permanent and Total Disability

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

Recreational Pilot

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

Rehabilitation Benefit

If you or your covered Spouse/Domestic Partner or Dependent Child suffer an accidental dismemberment or paralysis covered by this Plan, the Plan will reimburse up to $5,000 of Covered Rehabilitative Expenses that are incurred within two years of the Covered Accident. The rehabilitation services must be Medically Necessary as determined by a Physician and the expenses cannot exceed the usual level of charges in your location. Charges that would not have been made if no insurance existed are not payable. In addition to these exclusions, Covered

Rehabilitative Expenses do not include any expenses payable by Workers' Compensation or other similar law.

Repatriation of Remains

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

Seat Belt and Air Bag

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

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

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

Severe Burns

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

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

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

Terrorism Scare

The Plan will pay a benefit when the Insured Person suffers one or more losses for which accidental death, dismemberment, coma, or paralysis benefits are payable as a result of a Terrorism Scare (1) that is directed at the Company or its property or assets; (2) that is not an act of the Insured Person, or an employee of the Company, or a former employee of the Company whose employment ended less than 6 months before the date of the Terrorism Scare; and (3) that occurs while the Insured Person is performing their assigned occupational duties for the Company while in or on the premises of the Company. The benefit payable is $500,000. Only one benefit is payable per Insured Person for all losses as a result of the same Terrorism Scare.

War Risk

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

Carjacking

Effective January 1, 2022, the Plan will pay a benefit when the Insured Person suffers one or more losses for which accidental death, dismemberment, coma, or paralysis benefits are payable as a result of a Carjacking that occurs while the Insured Person is operating, or riding as a passenger in, (including getting in or out of) such Automobile.

The amount payable under the Plan is the lesser of: (1) $10,000; or (2) 10% of the largest benefit payable under any one of the Benefits specified above due to the Carjacking. Only one benefit is payable for all losses as a result of the same Carjacking.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

Psychological Therapy Benefit.

Effective January 1, 2022, if Injury to the Insured Person results within 365 days of the date of the accident that caused the Injury, in an accidental dismemberment for which an Accidental

Dismemberment benefit is payable under the Plan, the Plan will pay Covered Psychological Therapy Expenses that are due to the Injury causing the dismemberment. The Covered Psychological Therapy Expenses must be incurred within one year after the date of the accident causing the Injury. The amount payable for this benefit is the lesser of $10,000 or 10% of the Insured Person's Principal Sum. Covered Psychological Therapy Expenses do not include any expenses for or resulting from an Injury for which the Insured Person is entitled to benefits paid or payable by Workers' Compensation or other similar law. For these purposes, a Covered Psychological Therapy expense means an expense that: (1) is charged for a Medically Necessary Psychological Therapy Session for the Insured Person provided under the care or supervision of a Physician; (2) does not exceed the usual level of charges for similar therapy sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed. For these purposes, a Medically Necessary Psychological Therapy Session means any individual, joint or family mental health counseling session that: (1) is essential to assist the Insured Person in coping with the accidental dismemberment; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

BENEFICIARIES

Employee

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

Spouse/Domestic Partner

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

Dependent Child

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

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

other than a trustee and the Insured Person and the Insured Person's designated beneficiary die under circumstances in which it is not clear who died first, the designated beneficiary will be deemed to have predeceased you.

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

ADDITIONAL ASSIGNMENT INFORMATION

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

FILING A CLAIM FOR A PLAN BENEFIT

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

Deadline to File a Claim and File Proof of Claim

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

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

Claims for Plan Benefits

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

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

Notification of Accident

Within 60 days, or as soon thereafter as possible, notify HR Solutions of the accident, along with a brief description of the circumstances, the type of injury, the date and location of the accident, and the names of the Employee, Spouse/Domestic Partner and/or Dependent Child involved.

Your supervisor, business partner, family member, or beneficiary may provide this notification on your behalf.

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

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

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

Proof of Loss

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

How to File Accidental Death Claims

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

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

- If there is no Spouse/Domestic Partner, the full name, address, and birth date of each child. A certified copy of the Court appointment naming the guardian of the minor children's estate is needed as well
- If there is no child, the full name and address of the Insured Person's parents
- If there are no parents, the full names and addresses of the Insured Person's brothers and sisters
- If there are no brothers and sisters, a certified copy of the Court appointment naming the Administrator or Executor of the participant's estate

Send the completed claim to:
VGA Claims Processor
The Dow Chemical Company
North America Benefits
P. O. Box 2169
Midland, MI 48641-2169

The VGA Claims Processor will forward your Claim to:
NUFIC
Accident and Health Claims Division
P. O. Box 25987
Shawnee Mission, KS 66225-5987
1-800-551-0824

How to File Severe Burn and Accidental Dismemberment/Paralysis Claims

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

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

Send the completed claim to:

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

The VGA Claims Processor will forward your Claim to:

NUFIC
Accident and Health Claims Division

P.O. Box 25987
Shawnee Mission, KS 66225-5987
1-800-551-0824

How to File Permanent Total Disability Benefit Claims

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

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

Send the completed claim to:

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

The VGA Claims Processor will forward your Claim to:

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

Legal Actions

No action at law or in equity may be brought to recover on this Plan prior to the expiration of the Applicable Limitations Period described in the main body of this SPD.

Initial Decision on a Claim for Plan Benefits

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

a determination of disability will be decided in accordance with this Appendix, and all other Claims for Benefits will be decided in accordance with this Appendix.

Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims

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

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

Permanent Total Disability Benefit Claims for Claims

The Initial Claims Reviewer for Claims for Plan Benefits will review your Claim and notify you of its decision to approve or deny your Claim.

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

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

- The specific reason or reasons for the denial of the Claim;

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

Appealing a Denial of a Claim for Plan Benefits

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

Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims

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

- Employee name;

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

Send the appeal to:

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

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

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

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

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

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

Permanent Total Disability Benefit Claims

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

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

Send the appeal to:

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

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

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

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

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

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

ADDITIONAL DEFINITIONS

Appeals Administrator means, with respect to reviewing an adverse Claim for Plan Benefits, NUFIC. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in

accordance with the Plan Document. The person, group of persons, or entity designated as the Appeals Administrator for Claims for an Eligibility Determination is listed in Section 18.

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

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

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

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

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

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

- natural child from the moment of birth;
- legally adopted child;
- step-child who permanently resides in the Insured Employee's household;
- foster child; or
- child for whom the Insured Employee or their Spouse/Domestic Partner is the legal guardian, who permanently resides in the Insured Employee's household.

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

Your child is not eligible if the child:

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

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

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

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

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

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

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

Initial Claims Reviewer means, with respect to deciding Claims for Plan Benefits, NUFIC. The Initial Claims Reviewer with respect to deciding Claims for an Eligibility Determination is the person, group of persons or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons or entity designated as the Initial Claims Reviewer for Claims for an Eligibility Determination is listed in Section 18.

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

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

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

Limb means entire arm or entire leg.

Loss with respect to hand or foot means complete severance through or above the wrist or ankle joint; with respect to eye means total and irrecoverable loss of the entire sight in that eye;

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

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

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

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

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

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

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

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

Uniplegia means the complete and irreversible paralysis of one Limb.

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

Appendix C. Long Term Disability Information

Section 25. Appendix C. Long Term Disability Insurance Information

25.1 Long Term Disability 1

Former SPD Name:	The Dow Chemical Company Long Term Disability Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008) - Dow AgroSciences Long Term Disability Insurance Plan
Legal Plan Name:	The Dow Chemical Company Long Term Disability Program Applicable To Those Fully Disabled Prior To January 1, 2008
Legal Plan Number:	Plan 506
Claims Administrators for Claims for Plan Benefits:	UNUM Life Insurance Company administers claims under a group policy. The address and telephone number for UNUM Life Insurance Company are: UNUM Life Insurance Company The Benefits Center P.O. Box 100158 Columbia, SC 29202-3158 (800) 858-6843

ADDITIONAL ELIGIBILITY INFORMATION

The Plan provides group long term disability insurance coverage to certain Dow AgroSciences, LLC ("Dow AgroSciences") employees who were Disabled before January 1, 2006. The Plan is closed to those who were not Disabled prior to January 1, 2006. There are no new enrollments in the Plan on or after January 1, 2006.

If you were actively at work on or after January 1, 2006 for more than 80 hours and were not Disabled prior to January 1, 2006, you are not eligible for this Plan. Contact the HR Service Center for more or information, or refer to one of the summary plan descriptions for The Dow Chemical Company Long Term Disability Program.

Plan Closed to New Participants Effective January 1, 2006

Regular Employees of Dow AgroSciences who were actively at work or on an approved Family Leave before January 1, 2006, and who became Disabled before January 1, 2006 were eligible to participate in the LTD Coverage Options described above, after completing 12 months of actual work. Generally, a "regular" Employee means a person who is scheduled to work at least 20

hours each week and is classified by the Company as either a "full-time" or "less than full-time" Employee.

Eligibility to participate does not extend to individuals who perform services for Dow AgroSciences as an independent contractor, consultant or contractor, or to individuals (such as contingent workers) who perform services for the benefit of Dow AgroSciences, and whose compensation for those services comes from a source other than the Company payroll.

The Claims Administrator for Claims for Eligibility Determinations determines eligibility. Interpretations and eligibility determinations by the Claims Administrator are final and binding on Participants.

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, refer to Section 18.

If You Transferred to Dow AgroSciences

If you transferred directly to Dow AgroSciences from employment with The Dow Chemical Company, Eli Lilly and Company (prior to July 1, 1997), Sanachem, Mycogen Corporation, Mycogen Seeds, Rohm and Haas Company, or certain affiliates of those companies, all of your actual work with that employer would have counted toward your eligibility to participate in the Plan.

COVERAGE DETAIL

When you completed one continuous year of service with Dow AgroSciences, you were required to select one of the following long term disability options:

- continuation of 50% of your monthly base salary; or
- continuation of 66-2/3% of your monthly base salary.

Your monthly base salary is your rate of pay in effect immediately before the date your Disability began. It does not include any bonuses, incentive pay, overtime pay, or other extra compensation.

ADDITIONAL ENROLLMENT INFORMATION

Enrollment is closed. Only those who were already enrolled prior to January 1, 2006, and were Disabled prior to January 1, 2006 may participate in this Plan.

Funding and Employee Contribution

Plan benefits are fully funded by insurance through UNUM. Dow AgroSciences paid the entire cost of coverage for the continuation of 50% of your monthly base salary. If you elected the 66 2/3% option, you paid an additional amount for the additional 16 2/3% of coverage based on your age as of January 1 each year and your monthly base salary on a pre-tax salary reduction basis under The Dow AgroSciences Flexible Spending Plan.

Effective Period of Coverage

In general, you became eligible for initial LID coverage when you completed the 12-month waiting period. Other effective dates may have applied if you became eligible following other changes in coverage levels, such as due to a change-in-status event.

When Coverage Ends

Coverage under the Plan ended on December 31, 2005 if you were not Fully Disabled as of that date. If you are a Participant on or after January 1, 2006, coverage under the Plan ends on the date any one of the following occurs:

- on the day your employment with Dow AgroSciences ended;
- when you go on an unpaid leave of absence of more than 90 days (you may elect to continue coverage during an approved unpaid leave of absence of 90 days or less);
- on the day you are no longer eligible to participate in the Plan;
- on the day for which you discontinue paying the required price tags for the coverage; or
- if the Plan is terminated.

RECEIVING BENEFIT PAYMENTS

You were eligible to receive benefits under the Plan when:

- your illness pay was exhausted,
- you continued to be unable to work because of an Injury or illness that requires you to be under the care of a Physician, and
- you were approved by UNUM, the LTD insurance carrier, for Plan benefits.

The insurance carrier may require at any time that you undergo a medical examination by a Physician of its choice to confirm that you continue to be disabled.

Generally, you were considered to have a disability under the conditions of the Plan if, because of an illness or injury:

- you are unable to perform each of the material duties of your regular occupation — and, after receiving benefits for 24 months, you cannot perform each of the material duties of any occupation for which you receive pay and for which you have reasonable training, education, experience, or
- you are performing at least one of the basic duties of your regular occupation or another occupation on a part-time or full-time basis and you are earning no more than 80% of your monthly "indexed pre-disability earnings."

Your "indexed pre-disability earnings" include your monthly base salary at the time you were approved for long term disability, adjusted by the Consumer Price Index or 10%, whichever is less, on the annual anniversary of the date you began receiving long term disability benefits.

When you are approved for long term disability benefits, your employment with Dow AgroSciences ends.

Full Disability Benefit

When you receive long term disability benefits under the Plan, unless you are earning more than 20% of your indexed pre-disability earnings, you receive monthly payments of either 50% of your monthly base salary or 66-2/3% of your monthly base salary (depending on your enrollment election), less any additional income that you are either receiving or are entitled to receive from the following sources:

- Social Security (primary Social Security benefit only);
- Workers' Compensation;
- Occupational Disease Law, or similar act;
- Disability income benefits from any other act or law (excluding Veterans Administration benefits); and/or
- Any other group insurance plan.

Your Plan benefits are not affected by any cost of living increases that you may receive from Social Security. If disability income benefits from the sources listed above are paid to you in a lump sum, that amount is pro-rated on a monthly basis over the period of time for which the sum is given, and this amount is used to determine your maximum benefits. If no time period is determined, the lump sum amount is pro-rated over your expected life.

It may be necessary to estimate the amount of your Social Security benefits for purposes of determining the amount of benefits you are eligible to receive. In this case, your monthly long term disability benefit is adjusted when the insurance carrier receives proof of the actual amount of Social Security benefits you are receiving or are eligible to receive. You are responsible for repaying to the insurance carrier any excess benefits under the Plan that you receive based on the estimated Social Security benefit amount.

The maximum long term disability benefit you may receive under the Plan is 515,000 per month. The minimum long term disability benefit you may receive under the Plan is the greater of (1) $100 per month, or (2) 10% of the monthly benefit before deductions for other income benefits.

If You Earn More Than 20% of Your Indexed Pre-Disability Earnings While Disabled

During the first 12 months after being approved for long term disability benefits, your monthly benefit as calculated in the "Full Disability Benefit" section was not reduced by any earnings you received until the gross monthly long term disability benefit (including your primary Social Security benefit if you are receiving one) plus your earnings are more than 100% of your base salary at the time you were approved for long term disability.

If your earnings cause your total Plan benefits to exceed 100% of your base salary at the time you were approved for long term disability, your long term disability benefit is required to be

reduced so that your total benefits do not exceed 100% of your base salary at the time you were approved for long term disability.

After the first 12 months following approval for long term disability, your monthly long term disability benefit is calculated using the following formula:

- your indexed pre-disability earnings, minus the monthly earnings you receive while disabled, divided by
- your indexed pre-disability earnings, multiplied by
- your monthly long term disability benefit as calculated in the "Full Disability Benefit" section (including your primary Social Security benefit if you are receiving one).

Example: Assume your base salary at the time you were approved for long term disability was $3,000 per month, your earnings from part-time employment are $1,200 per month, your gross monthly long term disability benefit is $2,000 a month (under the 66-2/3% Option) and the Consumer Price Index increased by 10% since you were approved for long term disability benefits so that your indexed pre-disability earnings are $3,000 plus 10%, or $3,300.

Your adjusted long term disability benefit would be:

- $3,300 minus $1,200 equals $2,100
- $2,100 divided by $3,300 equals 0.636
- 0.636 times $2,000 equals $1,272.

Your adjusted monthly long term disability benefit in this example would be $1,272. Proof of your monthly earnings must be provided to the insurance carrier on a quarterly basis. Benefit payments may be adjusted upon receipt of proof of your earnings.

Tax Treatment

Your Plan LTD payments are taxable. UNUM does not withhold taxes from your benefit on a mandatory basis. However, you may request additional withholding by completing a form W-4S. UNUM will mail you a W-2 statement each year that will report the amount of your taxable LTD benefit and the amount of tax withheld, if any. Because tax laws change, you should consult a professional tax adviser for further information.

When Your Benefit Payments End

Your long term disability benefits under the Plan end:

- when you are no longer considered disabled, as determined by the LTD insurance carrier;
- if you earn income that exceeds 80% of your indexed pre-disability earnings;
- when you die;

- when you reach age 65, if you became disabled prior to age 60; provided that the maximum benefit period is not less than 60 months; or
- according to the following schedule, if you became disabled at age 60 or older:

AGE AT WHICH YOU BECOME DISABLED	MAXIMUM BENEFIT
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 OR OLDER	12 months

If you are receiving pension benefits under The Dow Chemical Company Employees' Pension Plan ("DEPP"), into which the Dow AgroSciences Pension Plan was merged, you are not eligible to participate in the Plan, and you may not receive Plan benefits. If you are eligible for benefits under both the Plan and pension benefits, you must select one plan or the other.

Recurring Disabilities

A recurring disability is one that is either related to or caused by a prior disability for which you received benefits from the Plan. It will be treated as a continuation of the prior disability if you are again disabled within 90 calendar days after you return to work with Dow AgroSciences on a full-time basis, and you are performing all the basic duties of your occupation.

Benefits for recurring disabilities are paid subject to the conditions of the prior disability. In addition, you are not be eligible for benefits due to a recurring disability if you are receiving benefits from any other group long term disability policy, such as one offered by another employer.

If you return to work for Dow AgroSciences on a full-time basis for a period of 90 calendar days or more, a recurring disability is treated as a new period of disability. If you returned to work for Dow AgroSciences after December 31, 2005 for a period of at least 90 calendar days, you are no

longer eligible for benefits under the Plan; you may be eligible for LTD benefits under a different Dow-sponsored plan.

Survivor Benefit

Your eligible survivor will receive a lump sum payment equal to three times your gross monthly long term disability benefit (including your primary Social Security benefit if you are receiving one) if you die while you are receiving monthly benefits and after you have been disabled for at least 180 consecutive days.

Your eligible survivor is your Spouse. If you have no Spouse, your eligible survivors are your children under age 25. Benefits will be paid to your estate if you have no surviving Spouse or children under age 25.

LIMITATIONS AND EXCLUSIONS

The Plan does not pay benefits for disabilities resulting from:

- declared or undeclared war or acts of war;
- intentionally self-inflicted injuries; or
- your participation in a riot.

Pre-existing Medical Conditions

Pre-existing medical conditions were excluded from coverage for 12 months or until there have were covered expenses or treatment for that pre-existing medical condition for a 90-day period, whichever occurs first. A pre-existing medical condition is a sickness or injury for which you have received medical treatment, consultation, care, or services including diagnostic procedures, or have taken prescription drugs or medicines during the 90 days prior to the date of your participation in the Plan.

If you transferred to Dow AgroSciences directly from The Dow Chemical Company, Eli Lilly and Company (prior to July 1, 1997), Sanachem, Mycogen Corporation, Mycogen Seeds, Rohm and Haas Company or certain affiliates of those companies and you were eligible for long term disability benefits before your transfer, any pre-existing medical condition was not excluded from Plan coverage assuming you timely enrolled for the coverage.

Mental Illness Limitation

Benefits for a disability resulting from mental illness, except those for psychoses and organic brain diseases, may not exceed 24 months of monthly benefit payments unless you meet one of the following conditions:

- You are in a hospital or institution at the end of the 24-month period, in which case benefits are paid during the confinement.
    - If you are still disabled when discharged, benefits continue for a recovery period of up to 90 days.

  - o If you become reconfined during the recovery period for at least 14 days in a row, benefits are paid during the confinement and another recovery period of up to 90 more days.

- You continue to be disabled and become confined for at least 14 days in a row after the 24-month period, in which case benefits are paid during the confinement.

Benefits for mental illness where the diagnosis is "psychosis" or organic brain disease are not bound by the mental illness limitations described above and will be treated as any other illness. Psychosis generally means a mental disease or derangement for which you are receiving continuous treatment from a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology. The term "psychosis" includes schizophrenic disorders, dementia praecox, manic-depressive reactions, involutional melancholia, paranoia and paranoid states, senile psychosis, psychosis with cerebral arteriosclerosis, Karsakow's psychosis, or other correspondingly serious psychosis. It does not include psychoneurotic disorders or behavioral disorders such as anxiety reactions, hysteria, phobic reactions or obsessive-compulsive reactions.

Claiming a Benefit Payment; Proof of Continuing Disability

A UNUM Claim for Disability Benefits form is available by calling 1-800-858-6848. You were required to submit a written claim for benefits, including evidence of your disability, to Dow AgroSciences within 90 days after you were first eligible to begin receiving benefits. If it was not possible to provide evidence within 90 days after you were first eligible to begin receiving benefits, it must have been provided as soon as reasonably possible. Benefits will not be paid if evidence of a disability was not provided within one year after you were first eligible to begin receiving benefits. See the Claims Procedures in this Appendix for more information.

When you are receiving benefits, you also may be required to provide evidence that you continue to be disabled and are under the regular care of a Physician. Proof of continued disability must be given to the LTD insurance carrier within 30 days of the request for documentation. Evidence must show the:

- date your disability began;
- cause of the disability; and
- seriousness of the disability.

Your employment with Dow AgroSciences ends when you are approved for benefits under the Plan.

ANCILLARY BENEFITS

Although your employment with Dow AgroSciences ended when you were approved for benefits under the Plan, you were permitted to continue to be enrolled in certain employee benefit plans ("ancillary benefit plans"), as such plans are amended from time to time. Please note that these ancillary benefits are not provided under the Plan. Instead, the terms of the ancillary benefit plans may extend eligibility to you because of your status under the Plan.

The following information is provided here only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern.

- Medical Coverage. If benefits under the Dow AgroSciences Illness Pay Program were exhausted before you were approved for long term disability benefits, you generally could continue your health care benefits under COBRA continuation coverage. Once you were approved for benefits under the Plan, you were eligible to continue coverage under either The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program for you and your eligible and covered dependents. In general, your cost for coverage is determined according to the retiree cost schedule, based on your years of service as an active Employee. Contact the Retiree Service Center for more information.
- Medicare. If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).
- Life Insurance. While you receive benefits under the Plan, you continue to be eligible for employer-paid life insurance coverage up to one times your annual base salary. In addition, if you were enrolled in supplemental employee-paid life insurance coverage as of your last day as an active Employee, you are eligible for life insurance coverage of an additional one times your annual base salary. Dow currently pays the cost of these coverages.
- Dependent Life Insurance and Accidental Death and Dismemberment Insurance coverages were terminated on December 31, 2005. The deadline for converting one or both of the terminated coverages to a private policy was January 30, 2006.
- Business Travel Accident (BTA) Insurance coverage, and Occupational Accident Insurance coverage ended when you were approved for benefit payments under the Plan.
- Health Care Flexible Spending Account (HCFSA) or Dependent Care Flexible Spending Account (DCFSA). If you were enrolled in HCFSA or DCFSA, you were permitted to continue coverage only for the year in which you were approved for Plan benefits. You were required to submit any claims under HCFSA or DCFSA before June 30 of the following year. Any remaining amounts were forfeited as of that date.

- Savings Plan. After you were approved for benefit payments under the Plan, you were not permitted to continue to make contributions to the Dow AgroSciences Employee Savings Plan or any successor.
- Pension Plan. You may not receive both benefits under the LTD Plan and benefits under the Dow Employees' Pension Plan (the "DEPP," into which the Dow AgroSciences Pension Plan was merged). If you are eligible for both benefits, you must select one plan or the other. Your compensation used in calculating your pension benefit is your earnings as an active Employee before the commencement of your long term disability payments. The following rules also apply following approval to receive Plan benefits:
    - If you were approved for long term disability benefits on or after January 1, 1991 and before January 1, 1994, you earn one year of credited service in the DEPP for each plan year that you receive long term disability benefits before January 1, 1994. Beginning on January 1, 1994 and continuing until your retirement, you earn one-half year of credited service for each plan year that you receive long term disability benefits.
    - If you are approved for long term disability benefits on or after January 1, 1994, you earn one-half year of credited service in the DEPP for each plan year that you receive long term disability benefits until your retirement.
    - If you are hired on or after January 1, 1996, you earn one-half year of eligibility service in the DEPP for each plan year you receive long term disability benefits, but only if you have completed five years of vesting service as of the date you are approved to receive long term disability benefits.
    - If you were hired on or before December 31, 1996 and are receiving long-term disability benefits, you are credited with one year of vesting service in the DEPP for each plan year you receive long term disability benefits. If you were hired on or after January 1, 1997 and are receiving benefits under the Plan, you are not credited with any vesting service during any plan year in which you receive long term disability benefits unless you accumulate 1,000 or more hours of regularly scheduled work during that plan year.

ADDITIONAL TAX CONSEQUENCES INFORMATION

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

Since tax laws change, you should consult a professional tax advisor for further information.

ADDITIONAL FUNDING INFORMATION

Benefits are funded through a group insurance contract with UNUM Life Insurance Company. Insurance premiums were paid by company contributions, and in some cases, by Employee contributions.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for Plan Benefit - The Initial Claims Reviewer and the Appeals Administrator is UNUM.

Time Limitation for Filing a Claim and Filing Proof of Claim

Claims for Plan Benefits - You must file a Claim for Plan Benefits within 90 days after you are first eligible to begin receiving benefits. If it is not possible to provide evidence within 90 days after you are first eligible to begin receiving benefits, it must be provided as soon as reasonably possible. In any case, Plan benefits will not be paid if evidence of a disability is not provided within one year after you are first eligible to begin receiving benefits.

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

Claims for Plan Benefits

If you want to file a Claim for Plan benefits, you must complete a UNUM Claim For Disability Benefits form and provide documentation showing that you were Disabled during and for the time required under the Plan. Contact the HR Service Center at:

North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Administrator for the Dow AgroSciences Long Term Disability Insurance Plan
(800) 344-0661

The Plan manager will review and sign your completed UNUM Claim for Disability Benefits form, and forward the form and documentation to:

UNUM Life Insurance Company
P.O. Box 100158
Columbia, SC 29202-3158
Attention: Claims Administrator for the Dow AgroSciences Long Term Disability Insurance Plan

UNUM may require that you be examined by a Physician of its choice as a requirement for benefits to be paid.

Initial Determination

When you submit a Claim for disability benefits to UNUM, 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 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 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 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 Initial Claims Reviewer's sole discretion, 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 will decide the claim without the additional information.

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

- The specific reason or reasons for denial of the claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary;
- 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;
- 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;
- An explanation of the Plan's appeal procedures and the applicable time limits; and
- 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 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 the Initial Claims Reviewer's notice of denial, assuming that there are not extenuating circumstances, as determined by the Appeals Administrator 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
- Explanation of the reason why you are appealing the Initial Determination Send your appeal to:

  UNUM Life Insurance Company
  LTD Claims Unit, B098
  2211 Congress Street
  Portland, Maine 04122
  Attention: Claims Administrator for the Dow AgroSciences Long Term Disability Insurance Plan (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 Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator under applicable federal regulations. 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 take into account all comments, documents, records, etc. submitted to the Appeals Administrator that is related to the Claim, without regard to whether such information was submitted or considered in the initial determination. The Appeals Administrator will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator 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 may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

The Appeals Administrator 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 may have up to an additional 45 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 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 Appeals Administrator's sole discretion, 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 will decide the Claim

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

- The specific reason(s) why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement 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;
- If an adverse decision is based on advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- 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;
- 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;
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- A statement of your right to bring a civil action under section 502(a) of ERISA.

ADDITIONAL DEFINITIONS

Administrator: Either the Claims Administrator or the Plan Administrator.

Appeals Administrator: With respect to a Claim for Plan Benefits, the Appeals Administrator is UNUM. With respect to a Claim for an Eligibility Determination, the Appeals Administrators are the Global Benefits Director and the Associate Director of North America Benefits.

Code: means the Internal Revenue code of 1986, as amended.

DEPP: The Dow Employees' Pension Plan. The Dow AgroSciences Pension Plan was merged into the DEPP.

Initial Claims Reviewer: With respect to a Claim for Plan Benefits, UNUM, and means, with respect to a Claim for an Eligibility Determination, the North America Health and Welfare Plans Leader.

Policy: The group insurance contract with UNUM Life Insurance Company that provides for payment of the benefits provided under the Plan.

25.2 Long Term Disability 2

Former SPD Name:	The Dow Chemical Company Long Term Disability Program (Applicable to Those Actively at Work on or after January 1, 2008)
Legal Plan Name:	Long Term Disability Plan For Those Actively At Work 1/1/2008 And After
Legal Plan Number:	Plan 606
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits: Lincoln National Life Insurance Company Disability Claims PO Box 2578 Omaha, NE 68172-9688 To submit a Claim for Plan Benefits: For Pre-2002 DCC Employees and Post -2009 DCC Employees: The Hartford Life Insurance Company 151 Farmington Ave. Hartford, CT 06156 For Pre-2010 DCC Employees: The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102

ADDITIONAL ELIGIBILITY INFORMATION

If you were disabled prior to January 1, 2008 (and are not an Employee or former Employee of Dow Corning), please see the summary plan description entitled: "The Dow Chemical Company Long Term Disability Program Applicable to Those Fully Disabled Prior to January 1, 2008." If you have any questions about which of these plans applies to you, please call HR Solutions or file a Claim for an Eligibility Determination as described in the Claims Procedures in Section 18.

The Plan is provided to Full-Time and Less-Than-Full-Time active Employees who meet the eligibility criteria. It is offered at no cost to the Employee for up to a 50 percent income protection level ("Option 1"). An additional 16.7 percent (totaling 66.7 percent) of income protection ("Option 2") may be purchased by an eligible Employee who is a Full-Time active Salaried Employee or a Full-Time active Hourly Employee who is eligible for Option 2 under the terms of an applicable collective bargaining agreement. Benefits under the Plan are offset by

other disability benefits such as, but not limited to, Workers' Compensation, Social Security, and in some cases, pension benefits.

The Plan is a group disability income protection plan that is intended to provide income protection for you and your family in the event of a lengthy disability. The chart below highlights the general provisions of the Plan applicable to Employees who are actively at work on or after the later of January 1, 2008 or the participation date of the Employee's Participating Employer, which are discussed in more detail in the SPD and Plan Document. If you are a former employee of Dow Corning who was disabled before January 1, 2017 and covered under the DCC LTD Plan (i.e., Pre-2002 DCC Employees, Pre-2010 DCC Employees, and Post-2009 DCC Employees), refer to the section Dow Corning Disabled Before 2017.

You are generally eligible to participate in the Plan if you are a Regular, Full-Time or Less-Than-Full-Time Employee who is actively at work on or after the later of January 1, 2008, or the participation date of your Participating Employer. If you are a Bargained-for Employee, you are eligible to participate in the Plan only to the extent provided under the terms of your collective bargaining agreement.Certain exclusions apply, including if you voluntarily elect to commence pension benefits under a pension plan sponsored by a Participating Employer, and for pre-existing conditions.

You are "eligible" to participate in the Plan if you meet certain requirements. Even if you meet the Plan's eligibility requirements, you will not be entitled to receive benefits under the Plan until after you meet the requirements described in the Effective Date of Enrollment section.

Who is eligible for coverage?

If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., your coverage under the Plan began effective January 1, 2019 for purposes of both the limitation on benefits for employees with less than one year of continuous service and the Pre-Existing Condition Exclusion provisions described below. For the period January 1, 2019 through March 31, 2019, you were eligible as "Class 4" as described in the Lincoln group insurance policy as amended by Amendment 15 dated March 14, 2019. Effective April 1, 2019, you became eligible to participate in Options 1 and 2 of the Plan if you satisfied the eligibility requirements in this Appendix.

Except as provided in the Who is not eligible for coverage? section below, you are eligible to participate in the Plan as follows:

- If you are a Regular, Full-Time Salaried Employee of a Participating Employer who is actively at work or on a certain type of approved leave (described below) on or after the later of January 1, 2008, or the participation date of your Participating Employer, you are eligible to participate in Options 1 and 2 of the Plan.
- If you are a Regular, Full-Time Bargained-for Employee of a Participating Employer who is actively at work on or after the later of January 1, 2008, or the participation date of your Participating Employer, you are eligible to participate in

Options 1 and 2, but only if and to the extent provided under the terms of the collective bargaining agreement that applies to you.

- If you are a Less-Than-Full-Time Employee of a Participating Employer who is actively at work on or after the later of January 1, 2008, or the participation date of your Participating Employer, you are eligible for Option 1 of the Plan.
- If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), you may be eligible for the benefits described in the section Dow Corning Disabled Before 2017.

If you are enrolled in Option 2 as a Full-Time Employee, and then become a Less-Than-Full-Time Employee during the year, your Option 2 coverage will terminate at the time you change to Less-Than-Full-Time status.

Who is eligible on a leave of absence?

Eligibility for benefits under the Plan may continue during certain leaves of absence approved by a Participating Employer such as an approved leave under the Company's Military Leave Policy, Family Leave Policy, Medical Leave Policy, or unpaid leave policy. The benefits under the Plan shall be administered consistent with the terms of such approved leaves of absences. For more details on benefits continuation during an approved leave of absence, please refer to the HR Portal KnowledgeBase articles on benefits during leaves of absence, which are incorporated into the Plan and this SPD by reference. You must continue making any required contributions in order to keep your Option 2 coverage in effect. The contributions must be paid by payroll deduction (if available) or any other means the Plan Administrator deems appropriate or necessary to collect contributions.

If you return from a military leave or family leave, or other leave of absence authorized by the Participating Employer, your prior service with the Participating Employer will be included for purposes of determining whether you have completed the one year continuous service requirement described in the section entitled Eligible Employees with Less Than One Year of Continuous Service.

Who is not eligible for coverage?

Notwithstanding the Who is eligible for coverage? section, you are not eligible to participate in the Plan:

1. If you become Fully Disabled or Partially Disabled on or after the date you:
    - Transfer from the U.S. payroll and have earnings exempted from the U.S. Social Security tax.
    - Change to Part-Time status (Note: Part-Time status is different than Less-Than-Full-Time status).
    - Take a leave of absence during which you are not eligible to participate in the Plan under the terms of your leave.

- Terminate your employment with Dow and/or a Participating Employer.
- Receive pension benefits pursuant to a voluntary election to commence benefits under a pension plan sponsored by a Participating Employer. A "voluntary election" means an election to commence your pension benefit when you are not required to begin receiving your benefit under the terms of the pension plan or by law. You are eligible to participate in the Plan if you started receiving pension benefits under a Participating Employer's pension plan because you were required to begin receiving them. This provision is effective for Participants who become Fully Disabled on or after November 1, 2011. However, your payments under the Plan will be reduced to reflect your pension payments. If your pension payments are equal to or greater than your payments under the Plan, you will not receive payments under the Plan.

2. If you are, or were, a Union Carbide Employee:

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

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

3. If you have been approved for benefit payments under the Dow Long-Term Disability Plan Applicable to Those Fully Disabled Prior to January 1, 2008, the UCC LTD Plan, the Dow AgroSciences Long Term Disability Insurance Plan, the Rohm and Haas Company Health and Welfare Plan, or any other long-term disability plan sponsored by a subsidiary or affiliate of Dow.

4. If you are employed by Americas Styrenics LLC and you became Fully Disabled on or after June 18, 2010. Americas Styrenics LLC stopped being a Participating Employer, effective June 18, 2010.

5. If you are DCC Disabled Before 2017, you are not eligible to participate in Options 1 or 2 of the Plan. However, you may be eligible for the benefits described in the section Dow Corning Disabled Before 2017.

If you are not sure whether you are eligible to participate in the Plan (or whether you are eligible to participate in Options 1 and 2 of the Plan or for the benefits in the section Dow Corning Disabled Before 2017), you may request a determination regarding whether you are eligible by filing a Claim for an Eligibility Determination. See the Claims Procedures in Section 18.

COVERAGE DETAIL

There are two options for coverage under the Plan: Option 1 provides 50% of your Basic Monthly Earnings and Option 2 provides an additional 16.7% of your Basic Monthly Earnings (for a total of 66.7%). These amounts may be reduced by other disability-related income or pension payments that you receive. If you are a Less-Than-Full Time Employee, you are eligible only for Option 1.

ADDITIONAL ENROLLMENT INFORMATION

If you meet the eligibility requirements, you are automatically enrolled in Option 1, effective on the first day that you are Actively at Work for at least one day of your regularly scheduled work hours. If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., you were automatically enrolled in Option 1 effective as of the date you became an Employee, unless you elected Option 2 within 31 days from the date you became an Employee.

If you are a Full-Time Employee, you generally may enroll in Option 2 within 90 days after your date of hire or during open enrollment. Your enrollment in Option 2 will not become effective until the first day after you elect to enroll in Option 2 that you are Actively at Work as an Employee and have been Actively at Work for the 30 days immediately preceding that day.

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

Option 1 (50% income replacement) If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., for the period January 1, 2019 through March 31, 2019, you were eligible as "Class 4" as described in the Lincoln group insurance policy as amended by Amendment 15 dated March 14, 2019. Effective April 1, 2019, you were automatically enrolled in Option 1 of the Plan if you satisfied the eligibility requirements in this Appendix.

If you meet the eligibility requirements, you are automatically enrolled in Option 1. Your enrollment is not effective until the day you meet the Active at Work Requirement and will be subject to the Pre-Existing Condition Limitation described below. For Option 1 benefits, you meet the "Active at Work Requirement" on the first day that you are Actively at Work with the Participating Employer for at least one day of your regularly scheduled work hours.

Option 2 (additional 16.7% for total of 66.7% income replacement) If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., and otherwise satisfied the eligibility requirements for Option 2, you were eligible to enroll in Option 2 as of April 1, 2019.

If you are a Full-Time Employee, you may enroll in Option 2 at the following times after you meet the eligibility requirements:

1. within 90 days after your date of hire;
2. during open enrollment; or
3. within 90 days after a change in status event

Your enrollment in Option 2 will not become effective unless you meet the Active at Work Requirement and will be subject to the Pre-Existing Condition Limitation described below in this Appendix. If you meet the Active at Work Requirement:

- Your enrollment will be effective on the first day that you meet the Active at Work Requirement on or after January 1 following your election to enroll if you enroll during open enrollment.
- Your enrollment will be effective as of your date of hire if you enroll within 31 days after your date of hire.
- Your enrollment will be effective as of the Plan Administrator's processing date if the Plan Administrator receives your request for enrollment on day 32 through 90 after your date of hire.
- Your enrollment will be effective as of the change in status event if the Plan Administrator receives your request for enrollment within 31 days after a change in status event, and receives proof of the change in status event within 90 days of the change in status event.
- Your enrollment will be effective as of the Plan Administrator's processing date if the Plan Administrator receives your request for enrollment on day 32 through 90 after the change in status event and receives proof of the change in status event within 90 days of the change in status event.

For Option 2, you satisfy the Active at Work Requirement on the first day after you elect to enroll that you are Actively at Work as an Employee and have been Actively at Work as an Employee for the 30 days immediately preceding that day. If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., and otherwise satisfied the eligibility requirements for Option 2, your period of employment with a subsidiary of DowDuPont is counted for purposes of the 30-day Active at Work Requirement. Thus, if you elect Option 2 while you are not actively at work, you will not be covered under Option 2 unless or until you return to work for at least 30 days, even though you will be paying the premium for Option 2.

If you elect to enroll in Option 2 or to decrease your coverage to the 50% level, you may change your election during any subsequent open enrollment period or as a result of a change in status. If you elect to increase your Option 1 (50%) coverage to 66.7% by adding Option 2 (16.7%), the 66.7% protection will not become effective until you satisfy the Active at Work Requirement for Option 2. If you decrease coverage to the 50% level, the decrease will become effective on the later of the date the Plan Administrator receives notice of the change in status, or the date of the change in status event.

“Change in status” has the same meaning as “Family Status Change” in the Lincoln group insurance policy. A “change in status” means any one of the following events:

- Events that change your legal marital status, including marriage, death of Spouse, divorce, or annulment.
- Events that change your number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.
- A termination or commencement of employment by you or your Spouse;
- A change in hours of employment by you, your Spouse, or your Dependent that results in a change from full-time to part-time employment (or vice versa).
- You or your Spouse taking an unpaid leave of absence.

Documentation of a change in status is required to make an election change (such as evidence of loss of Spouse or Dependent’s employment, or any other form of proof the Plan Administrator deems appropriate.) The Plan reserves the right to, at anytime, request proof of a change in status. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent’s eligibility. Your dependent’s enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan.

FAILURE TO PROVIDE PROOF OF A CHANGE IN STATUS WITHIN THE TIME REQUIRED WILL RESULT IN NO COVERAGE, AND MAY RESULT IN RETROACTIVE CANCELLATION OF COVERAGE. IF THIS OCCURS, YOU MAY BE REQUIRED TO REIMBURSE THE PLAN FOR LONG TERM DISABILITY BENEFITS ALREADY PAID.

EMPLOYEE CONTRIBUTION

Dow provides Option 1 at no cost to you. If you enroll in Option 2, you are required to pay a premium in the amount described in the annual open enrollment materials.

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

Dow provides Option 1 coverage at no cost to you. If you enroll in Option 2, you are required to pay a premium in the amount described in the annual open enrollment materials. Premiums for Option 2 are paid with pre-tax dollars through The Dow Chemical Company Flexible Spending Plan (the “Flex Plan”). The Plan Administrator has the unilateral authority to reduce the benefit election of certain Participants if such a reduction is necessary to prevent the Plan or the Flex Plan from becoming discriminatory within the meaning of Code Section 125(b).

If the last payroll period for the year occurs partly during the current year and partly during the next year, the Plan Administrator has the full and complete discretion to modify your premium contributions for Option 2 in any way that the Plan Administrator deems administratively efficient, including modifying your contributions for the last payroll period without your consent.

If you are on a leave of absence approved by the Participating Employer that provides eligibility for Option 2, the Plan Administrator has the full discretion to make special administrative arrangements as are necessary, such as suspending your contributions on a temporary basis during the leave of absence, requiring you to repay premiums for the coverage when you return to work, requiring you to pay premiums in advance, or any other arrangements that are permitted under applicable law that the Plan Administrator deems appropriate.

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

RECEIVING BENEFIT PAYMENTS

In order to receive benefits under the Plan, (i) for the entire "Elimination Period" (typically 6 months), you must be continuously Fully or Totally Disabled or Partially Disabled and eligible for the Plan as described in Eligibility, above, (ii) file a Claim for Plan Benefits within ninety (90) days after the disabling event, (iii) file proof of disability within ninety (90) days after the end of the Elimination Period, and (iv) receive Lincoln's approval of the Claim for Plan Benefits.

The period of time over which you may receive disability benefits generally is determined based on your age and service as of the date that you become disabled. If you have less than one year of continuous service and become disabled, your payments will not be paid for longer than one year. In addition, if you are disabled due to substance abuse, you will not receive disability benefits for longer than 24 months, except as otherwise provided in the Substance Abuse Limitation section below.

Six-Month Elimination Period

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

In order to receive benefits under the Plan, for the entire "Elimination Period," you must be continuously Fully or Totally Disabled or Partially Disabled and eligible for the Plan (as described in Eligibility above). "Elimination Period" means, with respect to a period of disability, the later of:

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

   Disabled, or

b. the date you are no longer receiving payroll income from the Participating

   Employer's payroll department for salary continuation under a Dow personal illness or medical leave policy.

You may return to work without interrupting the Elimination Period for a trial period (up to 30 days). However, the Elimination Period will stop (and you must start a new Elimination Period) if you return to work for more than 30 calendar days. A new Elimination Period will begin with the first absence following the last day after your 30th day returned to work. No portion of the prior Elimination Period will count toward the new Elimination Period.

Return to work means working a minimum of at least the same number of regularly scheduled hours per week that you were regularly scheduled to work immediately preceding the first day of Disability or Partial Disability. During a period you return to work, you are considered to have returned to work for each calendar day until the next day you are either (1) Disabled and do not work, or (2) Partially Disabled.

If you have not been released to return to work, the following hours will not count toward your 30 day trial period: hours recorded by the employer as vacation, unexcused absence, personal illness, medical leave or family leave time.

If you have been released to return to work, then all calendar days are counted toward the 30 day trial period, including excused and unexcused absences, unless they are for the original disabling condition.

Example:

On January 1, Ann is a full-time employee and has an injury resulting in Full Disability. On March 1, Ann returns to work with a part-time schedule restriction on a trial basis. Ann works the following schedule—

- March 1 through April 5: 4 hours per weekday (part-time)
- Monday, April 6 through Sunday, April 19: 8 hours per weekday (released with no restrictions)
- Monday, April 20 through Tuesday, April 26: 4 hours per weekday (part-time)

Ann is not considered to have returned to work for the period March 1 through April 5 because they had been a full-time employee before the Disability and did not return as a full-time employee at that time. Ann is first considered to have returned to work without restrictions for the period of April 6 through 12, when they first work 40 hours in a week. Ann continues to be considered returned to work without restrictions until they are restricted from working a full-time schedule on Monday, April 20. Ann is considered to have returned to work on Monday, April 6 through Sunday, April 19, or 14 days.

If Ann again is released to return to work on a full-time basis from April 27 through May 17, they will have exceeded 30 return to work days on May 14, and they will be required to begin (and complete) a new Elimination Period to receive LTD Plan benefits if they must stop working again for the same or related disabling condition.

Full Disability and Total Disability Benefits

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

Primary Benefit Period (Phase 1) — Full Disability

The Primary Benefit Period (sometimes also called Phase 1 or First Phase) starts on the day after the Elimination Period ends, if Lincoln has approved your Claim for Plan Benefits. It is a period during which benefits are paid. In order for Lincoln to approve your Claim for Plan Benefits, you must be enrolled in the Plan (See the Effective Date of Enrollment section above) and you must be Fully Disabled.

You are "Fully Disabled" if you cannot, because of a sickness or an injury, perform your regular occupation or any other reasonably appropriate occupation your Participating Employer can provide. With respect to airplane pilots in the Participating Employer's Aviation Department, "Fully Disabled" or "Full Disability" also means you 1) fail, because of your health, to pass the Class II F.A.A. health examination, and 2) the Participating Employer certifies that you have not been redeployed to another job with a Participating Employer.

You will not receive benefits under the Plan if you fail to provide Lincoln proof, when Lincoln asks for it, that a Full Disability exists and/or continues to exist; or for any period of time during which you are not under the care of a doctor for that Full Disability. For further information please see the Certificate of Insurance for the Lincoln group insurance policy.

The Primary Benefit Period means with respect to a period of Full Disability, the period of time, if any, which starts on the day after the end of the Elimination Period and which ceases on the earliest of:

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

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

1. start after the effective date of your enrollment in the Plan; and
2. are separated by less than 6 continuous months of active work with the Participating Employer on a full-time basis.

Secondary Benefit Period (Phase 2) — Total Disability

The Secondary Benefit Period (sometimes also called Phase 2 or Second Phase) starts on the day after the Primary Benefit Period ends if Lincoln has approved your payment of benefits. It is a period during which benefits are paid. The Secondary Benefit Period means with respect to a Period of Disability, the period of time, if any, which starts on the day after the end of a Primary Benefit Period and ceases on the earlier of:

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

In order to be eligible for benefit payments during the Secondary Benefit Period, you must have been receiving benefit payments during the Primary Benefit Period, and you must meet the definition of Total Disability.

You are "Totally Disabled" if you cannot, because of a sickness or an injury:

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

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

You will not receive benefits under the Plan (1) if you fail to provide Lincoln proof, when Lincoln asks for it, that a Total Disability exists and/or continues to exist; or (2) for any period of time during which you are not under the care of a doctor for that Total Disability. For further information please see the Certificate of Insurance for the Lincoln group insurance policy.

TIMETABLE - FULL DISABILITY / TOTAL DISABILITY

Below is a table of key times beginning with Day 1. Day 1 is the date of the disabling event that starts the Elimination Period prior to the Primary Benefit Period. The chart is for illustrative purposes only, and makes the assumption that you file your Claim for Plan Benefits and proofs of Full or Total Disability on the first day of the fourth month after Day 1, and that the Claim is approved by Lincoln for payment effective as of the first day after the end of the 6-month Elimination Period.

Timetable

Day 1: Disabling event resulting in a Full Disability or Partial Disability. This is the beginning of the six (6)-month Elimination Period. For the entire Elimination Period, you must be continuously Fully Disabled or Totally Disabled or Partially Disabled and eligible for the Plan as described in Eligibility beginning above (except as otherwise described in this SPD).

You should begin the application process. Call HR Solutions, fill out forms, obtain medical records, and file a Claim for Plan Benefits with Lincoln.

90 Days after Day 1: The deadline to file a Claim for Plan Benefits with Lincoln is 90 days after Day 1.

6 Months after Day 1: End of the six (6)-month Elimination Period. (assuming that approved medical leave was not extended beyond the 6 months).

6 Months and 1 Day after Day 1: Beginning of the Primary Benefit Period. You must be Fully Disabled during the Primary Benefit Period.

90 Days after end of Elimination Period: The deadline to file proof of Full Disability with Lincoln is 90 days after the end of the Elimination Period.

30 Months after Day 1: End of Primary Benefit Period.

30 Months plus 1 day after Day 1: Beginning of the Secondary Benefit Period. You must be Totally Disabled during the Secondary Benefit Period.

Deadline to File a Claim

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

The deadline to file a Claim for Plan Benefits with Lincoln is ninety (90) days after Day 1.

The deadline to file proof of a Full Disability with Lincoln is ninety (90) days after Day 1. (Lincoln may require proof of Full Disability or Total Disability at any time as it may reasonably choose.)

Example 1:

Matt has an injury that results in them becoming Fully Disabled beginning on January 1. January 1 is Day 1. Matt has 90 days from January 1 to file a Claim for Plan Benefits with Lincoln.

Example 2:

Ginger has an injury that results in them becoming Fully Disabled beginning on January 1. January 1 is Day 1. On February 1, Ginger begins working the same number of regularly scheduled hours per week they were regularly scheduled to work immediately before becoming Fully Disabled on January 1. Because Ginger "returned to work" (within the meaning described above), the Elimination Period is interrupted. On March 15, Ginger again cannot work due to a Full Disability. Ginger's new Day 1 is March 15, and they have 90 days from March 15 to file their Claim for Plan Benefits with Lincoln. (Note: The Elimination Period starts over on March 15, because they "returned to work" for more than 30 calendar days between February 1 and March 15.)

Note that if there are extenuating circumstances that justify it, Lincoln may extend the 90-day deadline. The decision on what constitutes an extenuating circumstance is at the complete discretion of Lincoln.

See the Claims Procedures in this Appendix for how to file a Claim for Plan Benefits.

Amount of Full Disability or Total Disability Payment

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If Lincoln approves a Claim for Plan Benefits, payment under Option 1 and Option 2 will provide an amount equal to the amount described in Part A below, subject to any reductions described in Part B, below.

<u>Part A</u>

Option 1

50% of your Basic Monthly Earnings, up to a maximum benefit of $142,500 per year (or $11,875 per month).

Option 2

Additional 16.7% of your Basic Monthly Earnings (for a total of 66.7%), up to a maximum benefit of $190,095 per year (or $15,841.25 per month).

For Full Time Salaried Employees, "Basic Monthly Earnings" means the amount of your base monthly salary as of your last active day at work, as determined by your employer. If you are a Less-Than-Full-Time Employee, "Basic Monthly Earnings" means your unreduced annual salary as of your last active day at work, as determined by your employer, divided by twelve. For Hourly Employees, "Basic Monthly Earnings" is your base hourly rate multiplied by 2080, divided by 12 months. "Base hourly rate" means your base hourly rate of pay as of your last active day at work, as determined by your employer. For Deer Park bargained-for employees who receive a Department Relief Operations (DRO) premium, the DRO premium is added to base hourly rate in the annual pay calculation.

If you are a Union Carbide employee, the "Basic Monthly Earnings" will be determined using your annual pay at Union Carbide as of December 31, 2001, as determined under the provisions of the Union Carbide Basic Life Insurance Plan until your annual base salary calculated under the normal provisions of the Plan exceed such amount. At that time, the Plan will determine your Basic Monthly Earnings under the normal provisions of the Plan (described in the preceding paragraph).

The maximum Basic Monthly Earnings, when combining both Company-Paid coverage plus Employee-Paid coverage, is $15,841.25 ($11,875 Company-Paid plus $3,966.25 Employee-Paid).

Part B

The amount determined in Part A may be reduced by the following amounts:

1. Other disability-related benefits and other income earnings (described below),
2. Any base pay you may receive under Dow's personal illness, medical leave policy, or other form of Dow authorized salary continuation (but not including vacation pay) that overlaps the Primary Benefit Period, and
3. Any pension benefits that you receive under a Participating Employer's pension plan because you are required to begin receiving them. This provision is effective for (1) Participants who became Fully Disabled on or after November 1, 2011 and whose pension payments commenced before they became disabled; and (2) Participants who receive benefits under the Plan on or after January 1, 2013 and are later required to begin receiving benefits under a Participating Employer's pension plan. If your pension payments are equal to or greater than your payments under the Plan, you will not receive payments under the Plan.

Disability-related benefits include:

- Social Security. The amount of disability and/or retirement benefits under the U.S. Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar government plan or benefit, which you are eligible to receive. If requested by Lincoln, you must apply for and actively pursue a Social Security disability benefit, through the administrative law judge level of appeal.
- Workers' compensation, or similar provisions including the Jones Act and the Longshoremen and Harbor Workers' Act, and any amounts resulting from a lawsuit for a Participating Employer work-related injury.
- Employer-sponsored disability income programs for salary continuance.
- No-fault motor vehicle or similar insurance programs.

Other income earnings include:

- Partial Disability employment earnings.
- Earnings received from any form of employment, including severance.

Note: Before the Plan is obligated to pay you any amounts, you MUST show proof to Lincoln that you have applied for Social Security if Lincoln has requested that you apply for Social Security. Failure to do so will result in Lincoln estimating your Social Security benefits payable and reducing your LTD Plan benefits by that amount. In addition, in order to receive benefits under the Plan, if Lincoln has requested that you apply for Social Security, you are required to actively pursue a Social Security disability benefit. If a Social Security benefit is denied by the government, you must pursue your remedies under Social Security through the administrative law judge level of appeal at your own cost.

Part C

The Minimum Monthly Benefit is the greater of (a) $100 or (b) 10% of the amount of your monthly benefit described in Part A before any reductions described in Part B.

Partial Disability

Note: If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

To be eligible to receive Partial Disability benefits, you may be employed in your Dow job or another job, and you must (i) for the entire Elimination Period described above, be continuously Partially Disabled and eligible for the Plan (as described in Eligibility described above), and (ii) be earning between 20% and 80% of your Basic Monthly Earnings.

Proof

If you experience a loss of earnings due to injury or sickness that requires the regular attendance of a physician, you may be eligible to receive a Partial Disability benefit payment. You must provide Lincoln proof of Partial Disability. “Partial Disability” or “Partially Disabled” means that you, as a result of injury or sickness, are able to:

1. Perform one or more, but not all, of the material and substantial duties of your own occupation or any occupation on a full-time or part time basis; or
2. Perform all of the material and substantial duties of your own occupation or any occupation on a part time basis; and
3. Earn between 20% and 80% of your Basic Monthly Earnings.

A partial benefit payment will be made for the period of Partial Disability if you provide proof satisfactory to Lincoln of continued:

1. Partial Disability;
2. Regular attendance of a physician, and
3. Appropriate available treatment.

The proof of Partial Disability must be given upon Lincoln’s request and at your expense. In determining whether you are Partially Disabled, Lincoln will not consider employment factors including, but not limited to, interpersonal conflict in the work place, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification. For purposes of determining Partial Disability, the injury must occur and partial disability must begin while you are a participant in the Plan.

Amount of Partial Disability Payment

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

First 12 Months

For the first 12 months, the partial benefit payment for Partial Disability will be an amount equal to your Basic Monthly Earnings multiplied by 50% or 66.7% (depending on your benefits enrollment election), without any reductions from earnings. The partial benefit payment will be reduced only if the monthly amount payable under the Amount of Coverage (Full Disability or Total Disability) section plus any earnings exceeds 100% of your Basic Monthly Earnings. If the combined total is more, the monthly amount will be reduced by the excess amount so that the monthly amount plus your earnings does not exceed 100% of your Basic Monthly Earnings.

Following First 12 Months

Thereafter, the amount of your monthly benefit will determined using the formula (A divided by B) x C where:

A = Your Basic Monthly Earnings minus your earnings received while you are Partially Disabled. This figure represents the amount of lost earnings.

B = Your Basic Monthly Earnings.

C = The monthly benefit determined as described in the Amount of Coverage (Full Disability or Total Disability) section plus your earnings received while you are Partially Disabled.

When Disability Benefits End (Your Terminal Date)

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If your Claim for Plan Benefits has been approved by Lincoln and you are receiving benefit payments from the Plan, your benefit payments under the Plan will end when any one of the following first applies to your situation:

- You reach age 65, if your Full Disability or Total Disability or Partial Disability began before age 60.
- After 5 consecutive years of benefit payments, or when you reach age 70, whichever is earlier, if your Full Disability or Total Disability or Partial Disability began between ages 60 and 69.
- After 12 consecutive months of benefit payments, if your Full Disability or Total Disability or Partial Disability began between ages 70 and 74.
- After 6 consecutive months of benefit payments, if your Full Disability or Total Disability or Partial Disability began on or after age 75.
- When your pension payments begin pursuant to a voluntary election to commence your pension benefits or if the pension plan required your pension benefits to commence, when your pension payments are equal to or greater than your payments under the Plan. A "voluntary election" means an election to commence your

pension benefit when you are not required to begin receiving your benefit under the terms of the pension plan or applicable law.

- After 12 consecutive months of benefit payments, if you had not completed one year of continuous service. See the Eligible Employees with Less than One Year of Continuous Service section, below.
- If you no longer meet the definition of Full Disability for the Primary Benefit Period, you no longer meet the definition of Total Disability for the Secondary Benefit Period, or you no longer meet the definition of Partial Disability for Partial Disability payments.
- You receive disability payments from any other long term disability plan sponsored by The Dow Chemical Company or its subsidiaries or affiliates.
- After 24 months of benefit payments if you are Fully or Totally Disabled or Partially Disabled due to substance abuse, except as otherwise provided in the Substance Abuse Limitation section.
- You die. Your Survivor may be entitled to a lump sum payment upon your death if you meet certain conditions. See the Survivor Benefit section, below.

The date your benefits under the Plan end is your Terminal Date.

Eligible Employees with Less Than One Year of Continuous Service

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If you have less than one year of continuous service, you become disabled, and your Claim for Plan Benefits is approved by Lincoln, the payments will be limited such that they will not be paid for longer than 1 year after they begin, and they may end sooner if other provisions of the Plan described in this SPD apply.

If you are a rehire who did not meet the one year of continuous service requirement prior to your rehire and your Claim for Plan Benefits is approved by Lincoln, your payments under the Plan will be limited to one year if you did not complete one year of continuous service after you were rehired and before you became disabled.

If you are a rehire who met the one year of continuous service requirement prior to your rehire and your Claim for Plan Benefits is approved by Lincoln, the Plan will recognize your prior service.

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

In determining whether you have one year of continuous service:

- The Elimination Period does not count toward the requirement.

- Service includes any service with Dow Corning before January 1, 2017.
- If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., service includes service with a subsidiary of DowDuPont Inc.

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for disabilities resulting from:

- War, declared or undeclared, or any act of war;
- Intentionally self-inflicted injuries, while sane or insane;
- Active participation in a riot;
- The committing of or attempting to commit a felony or misdemeanor; or
- Cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while you are a covered person under the Plan.

Benefits are not payable for any Disability or Partial Disability subject to the Pre-Existing Condition Exclusion. Exceptions apply to certain mergers and acquisitions. Contact the Plan Administrator for more information. If you became an Employee as part of the separation of Dow Inc. from DowDuPont Inc., your “effective date of coverage” for purposes of the Pre-Existing Condition Exclusion is January 1, 2019. A Disability or Partial Disability is subject to the Pre-Existing Condition Exclusion, if it:

1. Is caused or contributed to by, or results from a Pre-Existing Condition (defined below), and
2. Begins in the first 12 months immediately after your effective date of coverage, unless you received no Treatment (defined below) of the condition for any three consecutive months after your effective date of coverage.

“Pre-Existing Condition” means a condition resulting from an injury or sickness for which you are diagnosed or received Treatment within three months prior to your effective date of coverage.

“Treatment” means consulting, receiving care or services provided by or under the direction of a physician including diagnostic measures, being prescribed drugs and/or medicines, whether you choose to take them or not, and taking drugs and/or medicines.

In addition, benefits will not be paid if you:

- Fail to follow your physician’s prescribed treatment.
- Are employed (other than as described in the Partial Disability section of this SPD).
- Fail to furnish proof of continued disability.
- Fail to reimburse the Plan for overpayments made to you by the Plan while you were waiting for Social Security approval.

- Are receiving pension benefits pursuant to a voluntary election to commence benefits under a pension plan sponsored by a Participating Employer. A "voluntary election" means an election to commence your pension benefit when you are not required to begin receiving your benefit under the terms of the pension plan or by law. You are eligible to participate in the Plan if you started receiving pension benefits under a Participating Employer's pension plan because you were required to begin receiving them. This provision is effective for Participants who become Fully Disabled on or after November 1, 2011. However, your payments under the Plan will be reduced to reflect your pension payments. If your pension payments are equal to or greater than your payments under the Plan, you will not receive payments under the Plan.
- During any period during which you are incarcerated.

If your coverage ceases during a leave of absence, no benefits will be paid for a Disability or Partial Disability occurring during the cessation of coverage. However, coverage will continue for Disabilities or Partial Disabilities occurring before the cessation of coverage.

INTERACTION WITH OTHER BENEFITS

Disability Benefits and Retirement Benefits

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If you are receiving pension benefits pursuant to a voluntary election to commence benefits under a pension plan sponsored by a Participating Employer, you are not eligible to participate in the Plan. A "voluntary election" means an election to commence your pension benefit when you are not required to begin receiving your benefit under the terms of the pension plan or by applicable law.

If you started receiving pension benefits under a Participating Employer's pension plan because you were required to begin receiving them and not because of a voluntary election, you are eligible to participate in the Plan. This provision is effective for Participants who became Fully Disabled on or after November 1, 2011 and whose pension payments commenced before they became disabled. However, your payments under the Plan will be reduced to reflect your pension payments. If your pension payments are equal to or greater than your payments under the Plan, you will not receive payments under the Plan.

If you are receiving benefits under the Plan and later begin receiving benefits under a Participating Employer's pension plan, your benefits under the Plan:

1. will stop when your pension payments begin pursuant to a voluntary election to commence your pension benefits.
2. will be reduced to reflect your pension payments if the pension plan required your pension benefits to commence. This provision is effective for Participants who receive

benefits under the Plan on or after January 1, 2013 and are later required to begin receiving benefits under a Participating Employer’s pension plan. If your pension payments are equal to or greater than your payments under the Plan, you will stop receiving payments under the Plan. For any period of time that you would have received payments under the Plan but for the offset of your pension payments, you will have LTD Status or PD Status as described in the Full Disability or Total Disability and Other Benefits section or the Partial Disability and Other Benefits section, as applicable.

The pension plans sponsored by Participating Employers include the Dow Employees’ Pension Plan (which includes, among others, the legacy Rohm and Haas Company Retirement Plan and the legacy Dow Corning Corporation Employees’ Retirement Plan), Union Carbide Employees’ Pension Plan, the South Charleston Sewage Treatment Company Retirement Income Plan, and any other pension plan sponsored by a Participating Employer.

Survivor Benefit

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If your Claim for Plan Benefits is approved by Lincoln and you begin receiving payments under the LTD Plan for a Full Disability or Total Disability (“LTD benefits”) that occurred on or after January 1, 2018, your Survivor (defined below) will be eligible for a survivor benefit if you die (1) after your Disability has continued for 180 more consecutive days and (2) while receiving LTD benefits. The survivor benefit is a lump sum benefit equal to three times your last monthly LTD benefit.

For the purposes of the survivor benefit, your “Survivor” is your Spouse or Domestic Partner, or, if none, your children under age 25. If you do not have a Survivor, your benefit is payable to your estate.

If your benefit is payable to your children, it will be made in equal shares to all children, including step children and legally adopted children. If any of your children are minors or incapacitated, their share of your benefit will be paid to the court-appointed guardian of the children’s property.

If any overpayment is due at the time of your death, the benefit payable hereunder is reduced by any amount of overpayment.

Full Disability or Total Disability and Other Benefits

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If your Claim for Plan Benefits is approved by Lincoln and you begin receiving payments for Full Disability or Total Disability under the LTD Plan (“LTD benefits”), you will be considered to have “LTD Status.” For any period of time that you would have received LTD benefits but for

the reductions described herein, you will have LTD Status. If you are receiving pension benefits pursuant to a voluntary election to commence benefits (as described in the Disability Benefits and Retirement Benefits section), you are not eligible to participate in the Plan and will not have LTD Status. When you have LTD Status, you are no longer an active Employee of a Participating Employer. While on LTD Status, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits do NOT come from the LTD Plan. Instead, because of your LTD Status, the terms of the ancillary benefit plans may extend eligibility to you. Check with your Participating Employer to find out whether your Participating Employer offers ancillary benefit plans that extend eligibility to those with LTD Status.

The following information is provided only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern. In addition, the Company reserves the right to amend, modify and terminate the ancillary benefit plans at any time in its sole discretion.

If you have LTD Status, coverage ends under the following plans on your last day on the payroll:

- Business Travel Accident (BTA) Insurance
- Voluntary Group Accident (VGA) Plan
- Group Legal Plan

Participation under the following plans is provided for part of the time you have LTD Status:

- Pension Plans

  If you have LTD Status, you will continue to accrue benefit service and vesting service under your pension plan, if at all, as provided in the plan documents for your pension plan. In general, LTD benefits are not treated as compensation under the pension plans. Contact the Retiree Service Center at 1-800-344-0661 for more information.

- Company-Paid Life Insurance

  If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), you are eligible for up to either 12 months or 24 months of coverage. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you were hired prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008) and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were hired prior to January 1, 2003 and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for life insurance coverage until you are no longer eligible to receive payments from LTD.

The amount of coverage is the same as the amount of coverage you had under the applicable company paid life insurance plan on your last day Actively at Work (either 1/2 X or 1X). Currently, the Company pays the cost of this coverage.

- Medicare.

If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).

- Dental Coverage

The Americas Styrenics LLC Dental Plan and The Dow Chemical Company Insured Health Program apply to Participants who are Americas Styrenics LLC employees. The Dow Chemical Company Dental Assistance Program and The Dow Chemical Company Insured Health Program apply to all other Participants.

If you either have less than ten (10) years of Service, or were hired on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), you are eligible for up to either 12 months or 24 months of dental coverage beginning on the effective date of your approval for LTD Status. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service, but less than ten (10) years of Service.

If you have ten (10) or more years of Service and were hired prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.

If you were a DCC Employee and your date of “full disability” (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of dental coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1)

year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.

- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for dental coverage until you are no longer eligible to receive payments from LTD.

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

- Dependent Care Flexible Spending Account (DCFSA)

  If you are enrolled in DCFSA, eligible expenses you incurred through the end of the last calendar year in which you were actively employed or during the grace period that extends until March 15th of the following year may be submitted for reimbursement up to the amount you contributed to the account. You must submit your claims by April 30 of the following year. After that date, any remaining account balance will be forfeited. You may not make deposits into your DCFSA after you receive your final paycheck.

- Employee-Paid Life Insurance

  If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), you are eligible for up to either 12 months or 24 months of employee-paid life insurance coverage. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

  If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you were hired prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008) and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.

  If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of employee-paid life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if

you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were hired prior to January 1, 2003 and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits.

The amount of coverage will depend on the amount of coverage you had on your last day Actively at Work. If you had 1/2X, then the coverage amount is 1/2 X. If you had 1X or more, then the amount is limited to 1X. You will be required to pay the same premiums active employees pay.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of life insurance coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for life insurance coverage until you are no longer eligible to receive payments from LTD.

This section does not apply to Dow Corning participants on LTD who were disabled prior to 2017. For more information on the rules that apply to this group, see the Section labeled "Dow Corning Disabled before 2017."

- Dependent Life Insurance

  If your date of Full Disability or Total Disability is on or after January 1, 2018, you may continue coverage for your dependents. The current rules provide that you may continue coverage until you are no longer eligible to receive LTD benefits. You must continue making any required contributions in order to keep your coverage in effect. For avoidance of doubt, Dow Corning participants on LTD who were disabled before January 1, 2018 are not eligible for dependent life insurance.

- Employees' Savings Plan (ESP)

  If you are a participant of the Dow Employees' Savings Plan or the Americas Styrenics LLC 401(k) Savings and Profit Sharing Plan, the applicable savings plan allows you to take distribution of your savings plan account (under the rules of the applicable plan) or defer receipt. If you defer, any investment earnings will continue to be reinvested in your account. While you are on LTD Status you may not contribute to your savings plan account balance.

- Health Care Flexible Spending Account (HCFSA)

  will reimburse you for (1) eligible medical expenses that you incurred prior to the effective date of your LTD Status; (2) eligible medical expenses that you incur before the end of the grace period (March 15th of the following year), if you elect to contribute the remaining balance of your HCFSA contribution for the year from your final paycheck on a pre-tax basis; or (3) eligible medical expenses that you incur for the period you purchase HCFSA COBRA continuation coverage with after-tax dollars, including through the March 15th grace period if you have COBRA continuation coverage on the last day of the year. If you elected to participate in HCFSA, you must submit your claims by April 30 of the following year. After that date, any remaining account balance will be forfeited. You may not make deposits into your HCFSA after you receive your final paycheck unless you have elected COBRA continuation coverage. COBRA continuation coverage is available only if you have unused amounts in your HCFSA account on the effective date of your LTD Status.

- Health Savings Account (HSA)

  If you have established an HSA, you may continue to use it to reimburse eligible medical expenses incurred while you have LTD Status. However, you will not be permitted to make contributions to the HSA through payroll deduction.

- Medical Coverage - Except Americas Styrenics

  This section does not apply to Participants who were employed by Americas Styrenics LLC who have LTD Status.

  If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), you are eligible for up to either 12 months or 24 months of medical coverage. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service. Coverage will be

provided under The Dow Chemical Company Retiree Medical Care Program or Union Carbide Retiree Medical Care Program, depending on which pension plan you are a participant of.

If you are eligible to participate in the Dow Employees' Pension Plan or the Union Carbide Employees' Pension Plan, and you were hired prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008) and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage will be provided under The Dow Chemical Company Retiree Medical Care Program or Union Carbide Retiree Medical Care Program, depending on which pension plan you are a participant of.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for medical coverage until you are no longer eligible to receive payments from LTD.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service. Coverage will be provided under the Rohm and Haas Company Retiree Medical Care Program, which is part of the Rohm and Haas Company Health and Welfare Plan.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were

hired prior to January 1, 2003 and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Coverage will be provided under the Rohm and Haas Company Retiree Medical Care Program, which is part of the Rohm and Haas Company Health and Welfare Plan.

You will be required to pay the same premiums active Employees pay for comparable coverage.

- Medical Coverage - Americas Styrenics

  This section applies to Participants who have LTD Status and were employed by Americas Styrenics LLC.

  If you have less than ten (10) years of service as defined under the Americas Styrenics LLC Retiree Reimbursement Account, whichever is applicable, you are eligible for up to either 12 months or 24 months of medical coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of service. The 24-month period applies if you have more than one (1) year of service, but less than ten (10) years of service.

  Medical coverage will be provided under the Americas Styrenics LLC Medical Plan if your employer is Americas Styrenics LLC.

  You will be required to pay the same premiums active employees pay. If you die while you are still eligible for the 12-month or 24-month period of medical coverage, your surviving Spouse of Record/Domestic Partner of Record may continue coverage for the remainder of the 12-month or 24-month period. After the expiration of the remainder of the 12-month or 24-month period, the surviving Spouse of Record/Domestic Partner of Record will be offered COBRA coverage, subject to the medical plan's COBRA rules.

- Vision Coverage

  If you are eligible to participate in the Dow Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008), you are eligible for up to either 12 months or 24 months of vision coverage. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

  If you are eligible to participate in the Dow Employees' Pension Plan, and you were hired prior to January 1, 2008 (regardless of whether your employer was a Participating Employer before January 1, 2008) and you have ten (10) or more

years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits. Notwithstanding the foregoing, any employment periods with DowDuPont Inc. do not count toward years of Service.

If you were a DCC Employee and your date of "full disability" (as defined in the applicable Appendix) is on or after January 1, 2017:

- You are eligible for coverage under the Program when your LTD benefit payments begin.
- If you were hired by DCC on or after January 1, 2006, or you have less than ten (10) years of DCC Service, you are eligible for up to either 12 months or 24 months of vision coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD status. The 12-month period applies if you have less than one (1) year of DCC Service. The 24-month period applies if you have one (1) year or more of DCC Service.
- If you were hired by DCC prior to January 1, 2006, and you have ten (10) or more years of DCC Service, you are eligible for vision coverage until you are no longer eligible to receive payments from LTD.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you were hired prior to January 1, 2003 and you have ten (10) or more years of Service, the current rules provide that you are eligible for coverage until you are no longer eligible to receive LTD benefits.

If you are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan, and you either have less than ten (10) years of Service, or were hired on or after January 1, 2003, you are eligible for up to either 12 months or 24 months of coverage. Coverage ends prior to the expiration of the 12-month or 24-month period if you no longer qualify for LTD Status. The 12-month period applies if you have less than one (1) year of Service. The 24-month period applies if you have more than one (1) year of Service.

You will be required to pay the full cost of coverage.

Partial Disability and Other Benefits

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

This section does not apply to Participants who were employed by Americas Styrenics LLC or to Participants with LTD Status.

If your Claim for Plan Benefits is approved by Lincoln and you begin receiving payments for Partial Disability ("PD benefits") under the LTD Plan, you will be considered to have "PD Status." For any period of time that you would have received PD benefits but for the reductions described on above, you will have PD Status. If you are receiving pension benefits pursuant to a voluntary election to commence benefits (as described in the Disability Benefits and Retirement Benefits section), you are not eligible to participate in the Plan and will not have PD Status. When you have PD Status, you remain an active Employee. While on PD Status, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits do NOT come from the LTD Plan. Instead, because of your PD Status, the terms of the ancillary benefit plans may extend eligibility to you. Thus, the following information is only provided for your convenience. If there is any inconsistency between this information and the information in the summary plan description or other legal" documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern. In addition, the Company reserves the right to amend, modify and terminate the ancillary benefit plans at any time in its sole discretion.

If you have PD Status, with respect to the plans listed below: (i) coverage will continue as if you were working the same schedule as immediately before you became disabled; and (ii) the rules that applied to you before you became disabled will apply while you have PD Status, except as described below (or if the rules are changed more generally). For instance, if immediately before you became disabled you were a Full-Time active Employee, you will continue to be eligible for benefits under the following plans as if you were a Full-Time active Employee.

- Business Travel Accident (BTA) Insurance
- Company-Paid Life Insurance and Employee-Paid Life Insurance

  You are eligible for the same coverage that you had immediately prior to your PD Status, and on the same terms. In general, this means you will have coverage of one times (1x) your base annual (full-time) salary as determined under the applicable plan documents for the company-paid and employee-paid life insurance benefits. You must continue making any required contributions in order to keep your coverage in effect. If your paycheck from the Participating Employer is not large enough to cover your entire premium for employee-paid life insurance, your Participating Employer will bill you directly.

- Dependent Life Insurance and Voluntary Group Accident (VGA) Plan

  You are eligible for the same amount of dependent life insurance and VGA coverage that you had immediately prior to your PD Status, and on the same terms. In general, this means that you may purchase coverage as described in the applicable plan documents for these benefits. You must continue making any required contributions in order to keep your coverage in effect. If your paycheck from the Participating Employer is not large enough to cover your entire premium, your Participating Employer will bill you directly.

- Medical Coverage, Vision Coverage, and Dental Coverage

  You are eligible for medical, vision, and dental coverage that you had immediately prior to your PD Status and on the same terms. You must continue making any required contributions in order to keep your coverage in effect. If your paycheck from the Participating Employer is not large enough to cover your entire premium, your Participating Employer will bill you directly.

- Dependent Care Flexible Spending Account (DCFSA)

  You may continue participation in this plan, as long as your paycheck from the Participating Employer is large enough to accommodate the pre-tax deduction amount. If it is not, your DCFSA contribution will not be taken.

- Pension Plan

  If you have PD Status, you will continue to accrue benefit service and vesting service, if at all, as provided in the plan documents for your pension plan. In general, LTD benefits are not treated as compensation under the pension plans. Contact the Retiree Service Center at 1-800-344-0661 for more information.

- Employees' Savings Plan (ESP)

  If you are a participant of the Dow Employees' Savings Plan, you may continue to contribute to your savings plan account (under the rules of the applicable plan).

- Health Care Flexible Spending Account (HCFSA)

  You may continue participation in the HCFSA plan, as long as your paycheck from the Participating Employer is large enough to accommodate the pre-tax deduction amount. If it is not, your HCFSA contribution will not be taken.

- Health Savings Account (HSA)

  If you have established an HSA, you may continue to use it to reimburse eligible medical expenses incurred while you have PD Status. You may also continue to make contributions to your HSA if you remain enrolled in the high deductible option under the medical plan (and you are otherwise eligible to make HAS contributions), as long as your paycheck from the Participating Employer is large enough to cover your contribution.

- Group Legal Plan
- Vacation

  Your vacation accruals will remain the same as during your pre-disability period through the end of the calendar year in which your PD Status commenced. Beginning January 1 of the subsequent calendar year, your vacation accrual will be based on your working hours in that year (assuming you remain in PD Status).

Substance Abuse Limitation

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

If you are Fully or Totally Disabled or Partially Disabled due to substance abuse, you will not receive benefits for more than 24 months, except:

- if you are in a hospital or institution for substance abuse (as determined by Lincoln) at the end of the 24-month period, your payments will extend through your period of confinement.
- if you are not confined in a hospital or institution for substance abuse (as determined by Lincoln), but are fully participating in an extended treatment plan (as determined by Lincoln) for the condition that caused the disability, your payments will be extended for up to a maximum period of 36 months.

"Substance abuse" means alcohol and/or drug abuse, addiction or dependency.

Medical Examinations

If you are a former employee of Dow Corning who was disabled before January 1, 2017, and covered under the DCC LTD Plan (i.e., DCC Disabled Before 2017), this section does not apply to you. Refer to the section Dow Corning Disabled Before 2017.

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

Information Exchanged Between the Plan and Your Employer

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

DOW CORNING DISABLED BEFORE 2017

Eligibility

This section applies to you if you are a former employee of Dow Corning who was disabled before January 1, 2017 and you were covered under the DCC LTD Plan.

Disabled Prior to January 1, 2010

If you were disabled prior to January 1, 2010, were receiving benefit payments from the DCC LTD Plan on December 31, 2016, and you continue to be disabled, you continue to be eligible for benefit payments as provided in records held by Dow Corning.

Disabled On or After January 1, 2010

If you were disabled on or after January 1, 2010, and before January 1, 2017, were receiving benefit payments from the DCC LTD Plan on December 31, 2016, and continue to be disabled, you continue to be eligible for benefit payments as provided in the Hartford insurance policy.

If you were disabled before January 1, 2017, and were covered by the DCC LTD Plan but have not submitted a claim for benefit payments from the DCC LTD Plan, you may begin the application process by calling HR Solutions, filling out forms, obtaining medical records, and filing a Claim for Plan Benefits with Hartford. Once Hartford has determined that you are disabled, you may have to satisfy an elimination period in order to receive benefits under the Plan. Refer to the Hartford insurance policy for more information.

COVERAGE DETAIL

Disability and Other Benefits

If your Claim for Plan Benefits is approved by Hartford and you begin receiving payments under the LTD Plan ("LTD benefits"), you will be considered to have "DCC LTD Status." When you have DCC LTD Status, you are no longer an active Employee of a Participating Employer. While on DCC LTD Status, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits do NOT come from the LTD Plan. Instead, because of your DCC LTD Status, the terms of the ancillary benefit plans may extend eligibility to you. Special provisions regarding the amount that you pay and the duration of those benefits may apply.

As described below, certain disabled individuals of DCC are eligible to continue participating in the life insurance and dental programs. To the extent that you are eligible for life insurance and dental coverages as one of the disabled individuals described in this section, your participation in the Program is subject to the same terms and conditions, and rights and privileges, as an Employee of Dow, unless otherwise stated.

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2017:

- You are eligible for coverage under the Program effective January 1, 2017.
- You are eligible for medical, life, dental and vision coverage as a DCC LTD Participant until the earlier of (a) the date you are no longer eligible to receive payments from the DCC LTD Plan or (b) the date you are considered "retired" (as defined below).

You will be considered "retired" and thus ineligible for the Program as a DCC LTD Participant as follows:

Age Became Disabled	Date Considered "Retired"
Less than 60	Date reach age 65

60-64	Date that is 5 years after received first payment under the DCC LTD Plan
65-68	Date reach age 70
69 or older	Date that is 12 months after received first payment under the DCC LTD Plan

Basic Life Insurance

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2017, you will be eligible for continued life insurance benefits as outlined below.

Coverage prior to age 65

Your amount of basic life insurance will equal the amount of such insurance in effect on your last day on the payroll. This amount is one times your base annual salary in effect on that date.

Coverage at age 65 or older

Beginning on the first day of the month following your 65th birthday, your life insurance will equal your base annual salary, rounded up to the next $1,000, and then multiplied by one (1x). On the date you reach age 66, your coverage amount is reduced 20 percent (of the original amount) each year until the date you reach age 70. Each reduction in your amount of basic life insurance will take effect on the first day of the month following the date you reach the applicable age.

The following chart summarizes your insurance

Age	**Coverage Amount**
65	1x base salary at time of Retirement plus $5,000
66	80% of 1x base salary at time of Retirement, plus $5,000
67	60% of 1x base salary at time of Retirement, plus $5,000
68	40% of 1x base salary at time of Retirement, plus $5,000
69	20% of 1x base salary at time of Retirement, plus $5,000
70+	$5,000

You will also be entitled to an accelerated benefit option in certain instances if you become terminally ill, as described in the policy, equal to up to 80% of your basic life insurance amount (not to exceed $500,000).

Supplemental Life Insurance

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2017, you will be eligible for continued life insurance benefits as outlined below.

You may purchase coverage in an amount equal to the amount of supplemental life insurance in effect on your last day on the payroll. This amount is 1 to 8 times your base annual salary in effect on that date. **Coverage ends at age 65.**

Premium information is communicated on the Dow U.S. Benefits Site. Premiums are subject to change.

You will also be entitled to an accelerated benefit option in certain instances if you become terminally ill, as described in the policy, equal to up to 80% of your basic life insurance amount (not to exceed $500,000).

Dependent Life Insurance

If you are a DCC LTD Participant and your date of "full disability" (as defined in the applicable Appendix) is before January 1, 2018, you are not eligible to continue dependent life insurance.

When Disability Benefits End

If your Claim for Plan Benefits has been approved by Hartford or Prudential and you are receiving benefit payments from the Plan pursuant to this Appendix, your benefit payments under the Plan under this Appendix will end on the earliest of the following:

- when you are no longer eligible for benefit payments as described in the Hartford insurance policy (for Post-2009 DCC Employees), the Prudential insurance policy (for Pre-2010 DCC Employees) or the records held by Dow Corning (for Pre-2002 DCC Employees);
- the effective date of a Plan amendment that terminates your coverage under the Plan;
- your death;
- as provided in a separate written agreement, or
- the date of termination of the Plan.

ADDITIONAL TAX CONSEQUENCES INFORMATION

Your Plan payments are taxable; provided that if you are a DCC Disabled Before 2017, your Plan payments may not be taxable if you paid for your coverage under the DCC LTD Plan on a post-tax basis. None of Lincoln, Hartford, nor Prudential withholds taxes from your benefit on a mandatory basis. However, you may request withholding by completing a Form W-4S. Lincoln, Hartford, or Prudential (as applicable) will mail you a Form W-2 each year that will report the amount of your taxable benefit and the amount of taxes withheld, if any.

Since tax laws change, you should consult a professional tax advisor for further information.

ADDITIONAL FUNDING INFORMATION

Benefits provided under the Plan to those Actively at Work on or after January 1, 2008 (January 1, 2017 for those hired by Dow Corning) are insured through an insurance policy underwritten by Lincoln National Life Insurance Company ("Lincoln").

Benefits provided under the Plan to Post-2009 DCC Employees, are insured through an insurance policy underwritten by Hartford.

Benefits provided under the Plan to Pre-2010 DCC Employees are insured through an insurance policy underwritten by Prudential and are subject to the terms of the policy in effect when they became disabled except to the extent that the SPD or Plan Document governs.

Benefits provided under the Plan to Pre-2002 DCC Employees, who continue to be disabled, and who were previously covered under the DCC LTD Plan, are paid from the Company's general assets.

Dow pays the difference between the full costs required to pay for the coverage provided under the Plan and the amount of premiums contributed by you.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for Plan Benefits - For Claims for Plan Benefits, the Initial Claims Reviewer and the Appeals Administrator are Lincoln (or Hartford or Prudential (as applicable) for DCC Disabled Before 2017).

Deadline to File a Claim and File Proof of Claim

Claims for Plan Benefits - As soon as possible after the event giving rise to the Full Disability or Partial Disability, call HR Solutions to begin the process of filing a Claim for Plan Benefits.

You must file a Claim for Plan Benefits within ninety (90) days after the Full Disability (also called the Phase 1 Disability or loss or Day 1) or Partial Disability, and you must file your proof of the Full Disability of Partial Disability within ninety (90) days after the end of the 6-month Elimination Period, otherwise your Claim for Plan Benefits will be denied (unless there are extenuating circumstances as determined by the Claims Administrator). If you file a lawsuit, you must do so in accordance with the Litigation section.

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 Dow's payroll.

Proof of Disability

General Rules apply to: Claimants who do not satisfy the requirements to be DCC Disabled Before 2017.

DCC Pre-2017 Rules apply to: Claimants who satisfy the requirements to be DCC Disabled Before 2017.

- In general you are DCC Disabled Before 2017, if you were hired by Dow Corning, were disabled before January 1, 2017, and were previously covered under the DCC LTD Plan. Claimants who are DCC Disabled Before 2017, are either a Pre-2002 DCC Employee, a Pre-2010 DCC Employee or a Post-2009 DCC Employee.
- You are a Pre-2002 DCC Employee if you were hired by Dow Corning, were disabled before January 1, 2002, and were previously covered under the DCC LTD Plan.
- You are a Pre-2010 DCC Employee if you were hired by Dow Corning, were disabled on or after January 1, 2002 and before January 1, 2010, and were previously covered under the DCC LTD Plan.
- You are a Post-2009 DCC Employee if you were hired by Dow Corning, were disabled on or after January 1, 2010 and before January 1, 2017, and were previously covered under the DCC LTD Plan.

General Rules

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

1. Fully Disabled during the Primary Benefit Period (Phase 1).
2. Totally Disabled during the Secondary Benefit Period (Phase 2).
3. Partially Disabled while receiving Partial Disability benefits.

Monthly benefits will not be paid:

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

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

A statement from a physician without objective evidence may not be sufficient proof of Full Disability or Total Disability. It is strongly recommended that you work with your doctor to make sure that Lincoln is presented with all available evidence (e.g., medical examination, tests)

to support your Claim to Lincoln that you meet the definition of Full Disability. For example, a current medical examination and tests should be obtained near in time to the date you file your Claim for Full Disability to show the current status of your disability. Medical examinations and tests by your treating physician are not paid for by the Plan.

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

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

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

DCC Pre-2017 Rules (applicable to DCC Disabled Before 2017)

If you are DCC Disabled Before 2017 and you are being paid monthly benefits under the Plan, the Plan has the right to request proof of Disability as often as it reasonably chooses. While disability benefits are being claimed under the Plan, you must provide proof as required by Hartford or Prudential (as applicable).

Claims for Plan Benefits

If you want to file a Claim for Plan Benefits, you must complete a Lincoln (or Hartford or Prudential (as applicable) for DCC Disabled Before 2017) claims form and provide documentation showing that you were Fully or Totally Disabled or Partially Disabled during, and for the time required under the Plan. See the Proof of Disability section, above. Contact HR Solutions at:

The Dow Chemical Company
North America Benefits
P.O. Box 2169
Midland, MI 48641
Attention: Plan Administrator for Long Term Disability Program Applicable to Those Actively at Work on or after January 1, 2008
1-833-693-6947

The Plan Administrator will review and sign your completed Lincoln (or Hartford or Prudential (as applicable) for DCC Disabled Before 2017) claims form and forward the form and documentation to:

If you are not DCC Disabled Before 2017:

Lincoln National Life Insurance Company
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

If you are DCC Disabled Before 2017:

For Pre-2002 DCC Employees and Post -2009 DCC Employees:

The Hartford Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156

For Pre-2010 DCC Employees:

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

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.

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:

If you are not DCC Disabled Before 2017:

Lincoln National Life Insurance Company
Disability Claims
PO Box 2578
Omaha, NE 68172-9688

Attention: Claims Administrator for The Dow Chemical Company Long Term Disability Program Applicable to Those Actively at Work on or after January 1, 2008 (Appellate Review)

If you are DCC Disabled Before 2017:

For Pre-2002 DCC Employees and Post -2009 DCC Employees:

The Hartford Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156

For Pre-2010 DCC Employees:

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

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

General Business

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, 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 Claims Filed by a Pre-2002 DCC Employee or a Post-2009 DCC Employee whose appeal was filed after April 1, 2018, regardless of when the initial claim was filed:

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. If the denial of your Claim on appeal is based on advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in denying your Claim on appeal;
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 denial of your Claim on appeal, or a statement that such explanation will be provided free of charge upon request;
7. A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
8. A statement of your right to bring a civil action under section 502(a) of ERISA.

For All Claims Filed after April 1, 2018 (and if you are a Pre-2002 DCC Employee or a Post-2009 DCC Employee whose appeal was filed after April 1, 2018 regardless of when the initial claim was filed):

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.

ADDITIONAL DEFINITIONS

"Active at Work Requirement" means:

a. For Option 1 benefits, you meet the "Active at Work Requirement" on the first day that you are Actively at Work with the Participating Employer for at least one day of your regularly scheduled work hours.

b. For Option 2, you satisfy the Active at Work Requirement on the first day after you elect to enroll that you are Actively at Work as an Employee and have been Actively at Work as an Employee for the 30 days immediately preceding that day.33

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

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Plan Benefits, Lincoln (or Hartford or Prudential (as applicable) for DCC Disabled Before 2017). 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 Section 18.

"Code" means the Internal Revenue code of 1986, as amended.

"DCC" means Dow Silicones Corporation (Dow Corning Corporation prior to January 31, 2018).

"DCC Employee" means an Employee who was hired by DCC before October 1, 2016. If an Employee is re-hired by DCC or a Dow Entity, the Employee's first hire-date with DCC will be recognized for purposes of determining whether the Employee was hired before October 1, 2016 as follows:

1. If the Employee's employment with DCC terminated prior to January 1, 2006 (referred to as the "pre-January 1, 2006 termination date"), and the Employee was subsequently re-hired by DCC before October 1, 2016, and participated in the pre-2006 formula of Appendix J of the Dow Employees' Pension Plan (formerly the Dow Corning Corporation Employees' Retirement Plan) and no other formula under the Dow Employees' Pension Plan after the Employee's re-hire date, the Employee's first hire-date will be recognized by the Plan.

2. If, as of the Employee's pre-January 1, 2006 termination date, the Employee was eligible for coverage under the DCC medical plan for retirees in effect on the date of the Employee's pre-January 1, 2006 termination date, the Employee's first hire-date will be recognized by the Plan.

3. If an Employee's date of re-hire with any Dow Entity is on or after October 1, 2016, and the Employee's first hire-date is not recognized under clauses (1) or (2) above, the Employee is not a DCC Employee.

"DCC LTD Plan" means the Dow Corning Long Term Disability Plan (DCC ERISA Plan #505), a component of both the Dow Corning Corporation Health and Welfare Benefits Plan for Active Employees and the Dow Corning Corporation Health and Welfare Benefits Plan for Retirees and Inactive Employees.

"DCC Disabled Before 2017" means Pre-2002 DCC Employees, Pre-2010 DCC Employees and Post-2009 DCC Employees.

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

"Dow Corning" means Dow Silicones Corporation (Dow Corning Corporation prior to January 31, 2018).

"Dow Entity" means a "participating employer" of either The Dow Chemical Company Retiree Medical Care Program, the Union Carbide Corporation Retiree Medical Care Program, or the Rohm and Haas Company Retiree Medical Care Program, as "participating employer" is defined by each of those respective programs.

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

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

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

b. the date you are no longer receiving payroll income from the Company's payroll department for salary continuation under a Dow personal illness or medical leave policy.

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

"Full Disability" or "Fully Disabled" means you cannot, because of sickness or an injury, perform your regular occupation or any other reasonably appropriate occupation your Participating Employer can provide. Full Disability may also be called "Phase 1 Disability." With respect to airplane pilots in the Participating Employer's Aviation Department, "Fully Disabled" or "Full Disability" also means you (1) fail, because of your health, to pass the Class II F.A.A. health examination, and (2) the Participating Employer certifies that you have not been redeployed to another job with a Participating Employer.

"Hartford" means The Hartford Life Insurance Company.

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

"Initial Claims Reviewer" means, with respect to deciding Claims for a Plan Benefit, Lincoln (or Hartford or Prudential (as applicable) for DCC Disabled Before 2017). 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 Section 18.

"Lincoln" means Lincoln National Life Insurance Company.

"LTD Status" means your Claim for Plan Benefits was approved by Lincoln and you are receiving payments for Full Disability or Total Disability under the LTD Plan ("LTD benefits").

For any period of time that you would have received LTD benefits but for the reductions described herein, you will have LTD Status. If you are receiving pension benefits pursuant to a voluntary election to commence benefits (as described in the Disability Benefits and Retirement Benefits section), you are not eligible to participate in the Plan and will not have LTD Status.

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

"Option 2" means the Plan option for an additional 16.7% benefit (for a total benefit of 66.7%) that may be purchased by an Employee who is eligible for the option.

"Part-Time" means approved to work under 20 hours/week and classified as having Part-Time Status.

"Partial Disability" or "Partially Disabled" means the Participant, as a result of injury or sickness, is able to:

1. perform one or more, but not all, of the material and substantial duties of their own occupation or any occupation on a full-time or part time basis; or
2. perform all of the material and substantial duties of their own occupation or any occupation on a part time basis; and
3. earn between 20% and 80% of their Basic Monthly Earnings.

"PD Status" means your Claim for Plan Benefits was approved by Lincoln and you are receiving payments for Partial Disability ("PD benefits"). For any period of time that you would have received PD benefits but for the reductions described herein, you will have PD Status. If you are receiving pension benefits pursuant to a voluntary election to commence benefits (as described in the Disability Benefits and Retirement Benefits section), you are not eligible to participate in the Plan and will not have PD Status.

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

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

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

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

"Post-2009 DCC Employees" means employees hired by Dow Corning who were disabled on or after January 1, 2010 and before January 1, 2017, and previously covered under the DCC LTD Plan.

“Pre-2002 DCC Employees” means employees hired by Dow Corning who were disabled before January 1, 2002, and previously covered under the DCC LTD Plan.

“Pre-2010 DCC Employees” means employees hired by Dow Corning who were disabled on or after January 1, 2002 and before January 1, 2010, and previously covered under the DCC LTD Plan.

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

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

“Retiree” means a former Employee (other than a DCC Employee) who was age 50 or older with at least 10 years of Service when their employment terminated with a Participating Employer and who is also a “retiree” under the terms of the DEPP component of the Dow Employees’ Pension Plan or the UCEPP component of the Union Carbide Employees’ Pension Plan.

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

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

“Service” as used in the Full Disability or Total Disability and Other Benefits section for certain “ancillary benefit plans” has the meaning summarized below. The following information is provided only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern.

For those who are eligible to participate in the Dow Employees’ Pension Plan and were hired by a participating employer (other than Rohm and Haas or Dow Corning) of the Dow Employees’ Pension Plan prior to January 1, 2008, “Service” means “service” as defined under the Dow Retiree Medical Care Program. For those who are eligible to participate in the Dow Employees’ Pension Plan and were hired by a participating employer (other than Rohm and Haas or Dow Corning) of the Dow Employees’ Pension Plan on or after January 1, 2008, “Service” means “Credited Service” recognized under the Dow Employees’ Pension Plan.

For those who are eligible to participate in the Union Carbide Employees’ Pension Plan and were hired by a participating employer of the Union Carbide Employees’ Pension Plan prior to January 1, 2008, “Service” means “service” as defined under the Union Carbide Retiree Medical

Care Program. For those who are eligible to participate in the Union Carbide Employees' Pension Plan and were hired by a participating employer of the Union Carbide Employees' Pension Plan on or after January 1, 2008, "Service" means "Credited Service" recognized under the Union Carbide Employees' Pension Plan.

For those who are eligible to participate in the legacy Rohm and Haas Company Retirement Plan portion of the Dow Employees' Pension Plan and were hired by a participating employer of the Rohm and Haas Company Retirement Plan prior to April 1, 2009, "Service" means "service" as defined under the Rohm and Haas Company Health and Welfare Plan. (Note that the Rohm and Haas Company Retirement Plan was closed to new hires as of April 1, 2009. Rohm and Haas Company became a participating employer of the Dow Employees' Pension Plan with respect to new hires on and after April 1, 2009.)

For Americas Styrenics employees, the Plan recognizes service with Chevron-Phillips Chemical immediately prior to Americas Styrenics employment.

For those who were hired by DCC before October 1, 2016 (i.e., DCC Employees) "Service" is the sum of your (1) "Credited Service" as defined in section 5.1(f) of Appendix J of the Dow Employees' Pension Plan ("Appendix J"), excluding service with other employers described in section 5.1(f)(ii) of Appendix J, and (2) service with Site Services, Inc.

For those who are eligible to participate in the Dow Employees' Pension Plan and were hired by DCC after September 30, 2016, "Service" means "Credited Service" recognized under the Dow Employees' Pension Plan.

"Survivor" means your Spouse or Domestic Partner, or, if none, your children under age 25.

"Terminal Date" means the date the Participant's Monthly Benefits end as described in the When Disability Benefits End section.

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

1. do their occupation; and
2. do any other occupation for which they are reasonably fit by their education, their training or their experience (including work with a Participating Employer, self-employment or work with another employer).

25.3 Long Term Disability 3

Former SPD Name:	The Dow Chemical Company Long Term Disability Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008)
Legal Plan Name:	The Dow Chemical Company Long Term Disability Program Applicable To Those Fully Disabled Prior To January 1, 2008
Legal Plan Number:	Plan 506
Claims Administrators for Claims for Plan Benefits:	To submit a Claim for Plan Benefits: MetLife Group Long Term Disability Claims P.O. Box 14590 Lexington, KY 40511-4590 To appeal a denied Claim for Plan Benefits: MetLife Disability P.O. Box 14592 Lexington, KY 40511-4592 Attention: Claims Administrator for The Dow Chemical Company Long Term Disability Program Applicable to Those Who Were Fully Disabled Prior to January 1, 2008 (Appellate Review)

ADDITIONAL ELIGIBILITY INFORMATION

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

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

The Plan is closed to those who were not Fully Disabled prior to January 1, 2008. No new enrollments on or after January 1, 2008 will be accepted. If you have questions about which of these plans applies to you, please call HR Solutions or file a Claim for an Eligibility Determination as described in Section 18.

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

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

Who is eligible for coverage?

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

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

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

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

Who is not eligible for coverage?

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

- Transfer from the U.S. payroll and have earnings exempt from the U.S. Social Security tax.
- Change to Part-Time status (Note: Part-Time status is different than Less-Than-Full-Time status).
- Take a Leave of Absence, other than a Family Leave, Military Leave, or other leave described in the Plan Document.
- Terminate your employment with Dow and/or a Participating Employer.
- Receive pension benefits under a pension plan sponsored by a Participating Employer. This provision does not apply to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

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

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

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

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

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan, or have been told that you are not, see Section 18.

COVERAGE DETAIL

Effective Date of Personal Benefits

Option 1 (50% income replacement)

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

Option 2 (66.7% income replacement)

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

Active at Work Requirement

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

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

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

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

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

immediately upon the Plan's receipt of the enrollment information and the Employee's satisfaction of the Active at Work Requirement.

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

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

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

Eligible Employees With One Year or More of Continuous Service

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

Amount of Coverage

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

Option 1

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

Or

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

<u>Option 2</u>

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

Or

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

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

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

Disability related benefits and income include:

- Social Security. You must apply for and actively pursue a Social Security disability benefit, through the administrative law judge level of appeal.
- Workers' compensation, or similar provisions including the Jones Act and the Longshoremen and Harbor Workers' Act, and any amounts resulting from a lawsuit for a Participating Employer work-related injury.
- Employer-sponsored disability income programs for salary continuance.
- No-fault motor vehicle or similar insurance programs.
- Rehabilitative employment earnings.
- Dependent Social Security exceeding 25 percent of your Monthly Base Salary (for Salaried Employees) for the 50 percent benefit, or exceeding 10 percent of your Monthly Base Salary (for Salaried Employees) for the 66.7 percent benefit. Dependent Social Security exceeding 25 percent of your Monthly Base Earnings (for Hourly Employees) for the 50 percent benefit, or exceeding 10 percent of your Monthly Base Earnings (for Hourly Employees) for the 66.7 percent benefit. Your dependents may qualify for Social Security benefits because of your disability. If so, your total combined income from Social Security and LTD may exceed the 50% or 66.7% benefit limitation, whichever is applicable.
- Pension payments from a Participating Employer's Pension Plan. This provision does not apply to LTD Participants whose Full Disability or Total Disability began

before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

Note: Before the Plan is obligated to pay you any LTD payments, you MUST show proof to MetLife that you have applied for Social Security. Failure to do so will result in MetLife estimating your Social Security benefits payable and reducing your LTD benefits by that amount. In addition, in order to receive LTD payments, you are required to actively pursue a Social Security disability benefit. If a Social Security benefit is denied by the government, you must pursue your remedies under Social Security through the administrative law judge level of appeal at your own cost.

Rehabilitative Employment

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

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

Proof of Claim

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

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

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

Medical Examinations

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

Information Exchanged Between the Plan and Your Employer

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

ADDITIONAL ENROLLMENT INFORMATION

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

Option 1 (50% income replacement)

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

Option 2 (66.7% income replacement)

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

EMPLOYEE CONTRIBUTION

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

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

If the last payroll period for Participants for a Plan Year occurred partly during a current Plan Year and partly during the next Plan Year, the Plan Administrator had the full and complete

discretion to modify the Participant contributions for Option 2 in any way that the Plan Administrator deemed administratively efficient, including modifying the Participant contributions for the last payroll period without the Participant's consent.

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

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

Reduction of Certain Elections to Prevent Discrimination

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

RECEIVING BENEFIT PAYMENTS

Six Month Elimination Period

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

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

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

- The number of hours of active work during the Elimination Period was 80 or fewer hours, and

- The same disability prevented you from working more than 80 hours during the Elimination Period.

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

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

Primary Benefit Period (Phase 1)

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

With respect to a Period of Disability, the period of time, if any, which starts on the day after the end of the Elimination Period and which ceases on the earliest of:

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

A Period of Disability is defined as:

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

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

will be considered as one continuous Period of Disability.

Definition of Fully Disabled or Full Disability

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

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

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

Secondary Benefit Period (Phase 2)

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

With respect to a Period of Disability, the period of time, if any which starts on the day after the end of a Primary Benefit Period and ceases on the earlier of:

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

Definition of Totally Disabled or Total Disability

You cannot, because of a sickness or an injury:

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

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

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

Timetable

Below is a table of key times beginning with Day 1. Day 1 is the date of the disabling event that starts the Elimination Period prior to the Primary Benefit Period. The chart is for illustrative

purposes only, and makes the assumption that the Participant files their claim for benefits and proofs of Disability on the first day of the fourth month after Day 1, and that the Claim is approved by MetLife for payment effective as of the first day after the end of the 6-month Elimination Period.

Day 1:

Disabling Event resulting in a Full Disability. This is the beginning of the six (6) month Elimination Period. You must be Fully Disabled continuously during the Elimination Period (except as otherwise described in this SPD).

3 Months after Day 1:

You should begin the LTD application process. Call HR Solutions, fill out forms, obtain medical records, and file a Claim for Plan Benefits with MetLife.

6 Months after Day 1:

End of the six (6) month Elimination Period.

6 Months and 1 Day after Day 1:

Beginning of the Primary Benefit Period. You must be Fully Disabled during the Primary Benefit Period.

30 Months after Day 1:

End of Primary Benefit Period.

30 Months plus 1 day after Day 1:

Beginning of the Secondary Benefit Period. You must be Totally Disabled during the Secondary Benefit Period.

Deadline to File a Claim

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

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

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

Example 2: Ginger has an injury that results in them becoming Fully Disabled beginning on January 1. January 1 is Day 1. Ginger returns to work on a trial basis on February 1. Ginger works for more than 80 hours, thus interrupting the Elimination Period. On March 1, Ginger cannot return back to work due to a Full Disability. Ginger’s new Day 1 was March 1, and they have 9 months from March 1 to file their claim with MetLife.

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

See Claims Procedures for how to file a Claim in this Appendix.

When LTD Benefits End

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

- You reach age 65, if your Full Disability or Total Disability began before age 60.
- After 60 consecutive months of benefit payments, or when you reach age 70, whichever is earlier, if your Full Disability or Total Disability began between ages 60 and 69.
- After 12 consecutive months of benefit payments, if your Full Disability or Total Disability began between ages 70 and 74.
- After 6 consecutive months of benefit payments, if your Full Disability or Total Disability began on or after age 75.
- If you begin receiving pension benefits under a Participating Employer's pension plan. If your Full Disability or Total Disability began before February 7, 2003, this provision does not apply to you if you began receiving pension benefits under UCEPP before that date.
- After 12 consecutive months of benefit payments, if you had not completed one year of continuous service.
- If you no longer meet the definition of Full Disability for the Primary Benefit Period, or you no longer meet the definition of Total Disability for the Secondary Benefit Period.
- You receive disability payments from the Union Carbide Long Term Disability Plan after the date that Elimination Period ends.

The date your LTD benefits end is your Terminal Date.

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for disabilities resulting from:

- Attempted suicide or any intentionally self-inflicted illness or injury.
- War, or a warlike action in time of peace or any participation in insurrection, rebellion or riot.
- Alcoholism, narcotic or other drug addiction.
- Committing or attempting to commit a felony, assault or other serious crime. In addition, benefits will not be paid if you:

- Fail to follow your physician's prescribed treatment.
- Are employed (other than the first six months of "rehabilitative employment" as defined and approved by MetLife).
- Fail to furnish proof of continued disability.
- Fail to reimburse the Plan for overpayments made to you by the Plan while you were waiting for Social Security approval.
- Are receiving pension benefits from a pension plan sponsored by a Participating Employer. This provision does not apply to LTD Participants whose Full Disability or Total Disability began before February 7, 2003 and who began to receive pension benefits from UCEPP prior to February 7, 2003.

INTERACTION WITH OTHER BENEFITS

LTD and Retirement Benefits

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

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

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

LTD and Other Benefits

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

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

If you have LTD status, coverage ends under the following plans on your last day on the payroll:

- Business Travel Accident (BTA) Insurance.
- Dependent Life Insurance. You or your dependents may convert this coverage within 31 days of the date your LTD status became effective and may select any non-term individual or dependent life insurance policy offered by MetLife with no

proof of insurability required. You are responsible for the cost of such coverage. For more information regarding conversion options, call MetLife at 877-275-6387 (877-ASK-MET7).

- Voluntary Group Accident (VGA) Plan.

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

- Company-Paid Life Insurance

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

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

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

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

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

- Medicare.

  If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).

- Dental Coverage

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

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

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

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

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

- Dependent Care Flexible Spending Account (DCFSA)

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

- Dow Employees' Pension Plan (DEPP)

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

- Employee-Paid Life Insurance

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

  If you had less than ten (10) years of service under DEPP or UCEPP, you were eligible for up to either 12 months or 24 months of employee-paid life insurance

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

The amount of coverage depends on the amount of coverage you had on your last day Actively at Work. If you had 1/2X, then the coverage amount is 1/2X. If you had 1X or more, then the amount is limited to 1X. You are required to pay the same premiums active employees pay.

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

You are eligible for coverage. Currently, eligibility for coverage ends when you are no longer eligible to receive payments from LTD. The amount of coverage depends on the amount of coverage you had on your last day on the payroll. If you had 1/2X, then the coverage amount is 1/2 X. If you had 1X or more, then the amount is limited to 1X. Currently, Dow pays the full cost to insure.

- Employees’ Savings Plan (ESP) allows you to take distribution of your Employees’ Savings Plan account or defer receipt. If you defer, any investment earnings will continue to be reinvested in your account. While you are on LTD status you may not contribute to your Employees’ Savings Plan account balance.
- Health Care Flexible Spending Account (HCFSA) reimbursed you for eligible medical expenses that you incurred prior to the effective date of your LTD status, if you elected to participate in HCFSA and up to the level of your participation. You must have submitted your claims by April 30 of the following year. After that date, any remaining account balance was forfeited. While on LTD status, you may not make deposits into your Reimbursement Accounts.
- Long Term Care (LTC) coverage can be continued with direct billing through John Hancock. Contact John Hancock at 1-800-582-4369.
- Union Carbide Employees’ Pension Plan (UCEPP). If you have ten or more years of credited service under UCEPP, you will continue to earn credited service toward UCEPP retirement benefits while receiving LTD benefits. You will earn one-half month of credited service under UCEPP for each month of disability payment provided by the LTD Plan, as specified under UCEPP until the date specified under UCEPP.
- Medical Coverage

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

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

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

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

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

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

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

ADDITIONAL TAX CONSEQUENCES INFORMATION

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

Since tax laws change, you should consult a professional tax advisor for further information.

ADDITIONAL FUNDING INFORMATION

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

Dow paid the premium for the 50 percent benefit. Employees paid for some or all of the cost of the additional optional 16.7 percent benefit. Plan benefits are funded by a group insurance contract with MetLife.

Any assets of the Plan may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as the Plan may be amended from time to time, as well as to pay for any expenses of the Plan. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses.

FILING A CLAIM FOR A PLAN BENEFIT

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

Deadline to File a Claim and File Proof of Claim

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

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

Proof of Disability

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

- Fully Disabled during the Primary Benefit Period (Phase 1), and
- Totally Disabled during the Secondary Benefit Period (Phase 2). Monthly Benefits will not be paid with respect to Full Disability or Total Disability:
- if you fail to provide proof that is satisfactory to MetLife when you file a Claim for Plan Benefits;
- if you fail to provide proof, when MetLife asks for it, that such disability exists and/or continues to exist; or

- for any period of time during which you are not under the care of a doctor for that Full Disability or Total Disability.

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

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

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

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

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

Claims for Plan Benefits

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

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

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

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

Initial Determination

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

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

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

1. The specific reason or reasons for denial of the Claim;
2. References to the specific Plan provisions upon which such denial is based;
3. A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
4. An explanation of the Plan’s appeal procedures and the applicable time limits;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your Claim, without regard to whether the advice was relied upon in

denying your Claim; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits);

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

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

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

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

Appealing the Initial Determination

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

- Name of Employee,
- Name of the Plan,
- Reference to the Initial Determination, and
- Explanation of the reason why you are appealing the Initial Determination. Send your appeal to:
- MetLife Disability
P.O. Box 14592
Lexington, KY 40511-4592
Attention: Claims Administrator for The Dow Chemical Company Long Term Disability Program Applicable to Those Fully Disabled Prior to January 1, 2008 (Appellate Review)

You may submit any additional information to the Appeals Administrator for Claims for Plan Benefits when you submit your request for appeal. You may also request that the Appeals

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

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

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

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.

ADDITIONAL DEFINITIONS

"Active at Work Requirement" means:

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

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

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Plan Benefits, MetLife. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Appeals Administrator for Claims for an Eligibility Determination is listed in Section 18.

"Code" means the Internal Revenue code of 1986, as amended.

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

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

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

a. the first 6 months that you are Fully Disabled and/or Totally Disabled, or
b. the date you are no longer receiving payroll income from the Company's payroll department.

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

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

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

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

Plan Document. The person, group of persons, or entity designated as the Initial Claims Reviewer for Claims for an Eligibility Determination is listed in Section 18.

"MetLife" means Metropolitan Life Insurance Company.

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

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

"Part-Time" means approved to work under 20 hours/week and classified as having Part-Time Status.

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

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

will be considered as one continuous Period of Disability.

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

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

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

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

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

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

"Retiree" means a former Employee who was age 50 or older with at least 10 years of Service when their employment terminated with a Participating Employer and who is also a "retiree"

under the terms of the DEPP component of the Dow Employees' Pension Plan or the UCEPP component of the Union Carbide Employees' Pension Plan.

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

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

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

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

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

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

a. do their job; and

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

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

25.4 Long Term Disability 4

Former SPD Name:	Rohm and Haas Company Health and Welfare Plan's Disability Program's Long Term Disability Program (applicable to closed population of Bargained-for Employees at Kilbourn Whose Disability Began Before January 1, 2010)
Legal Plan Name:	The Rohm and Haas Company Health and Welfare Plan
Legal Plan Number:	Plan 551
Claims Administrators for Claims for Plan Benefits:	Lincoln Group Benefits Disability Claims Lincoln National Life Insurance Company P.O. Box 7211 London, KY 40742-7211

ADDITIONAL ELIGIBILITY INFORMATION

If your Disability began on or after January 1, 2010, you are not eligible for the Plan, but you may contact the Dow Retiree Service Center to see whether you qualify under The Dow Chemical Company Long Term Disability Plan.

Eligible Employees

The Plan applies only to eligible bargained-for Employees of Rohm and Haas Company whose primary work location is the Kilbourn site and whose qualifying Disability or Partial Disability occurred before January 1, 2010. You are eligible for coverage under the Plan if:

- You were a bargained-for Employee of Rohm and Haas Company or a Participating Employer whose primary work location was the Kilbourn site and whose regular work schedule was greater than 20 hours per week and were in Active Employment prior to January 1, 2010;
- You were in Active Employment before January 1, 2010; and
- Your Disability began before January 1, 2010.

The definition of "Employee" does not include temporary employees (regardless of whether you are eligible for any other benefit), seasonal employees, leased employees, independent contractors, any person designated by Rohm and Haas Company or a Participating Employer at the time of hire as not eligible to participate in the Plan, even if such ineligible person is subsequently determined to be an "employee" by any government or judicial authority, or any member of a group or class not eligible for benefits as designated by the Employer.

Enrollment and Cost of Coverage

You did not need to enroll in the Plan; eligible Employees were automatically enrolled, and the Company paid the cost of the LTD income protection coverage.

Family and Medical Leave

If you were a Covered Person and your qualifying Disability occurred prior to January 1, 2010, you were permitted to continue coverage under this Plan if you were on an approved family or medical leave of absence for up to 12 weeks following the date coverage would have otherwise terminated, subject to the following:

- The authorized leave must have been in writing.
- The Covered Person's benefit level, or the amount of earnings upon which the Covered Person's benefit may be based, is that in effect on the date before such leave began.
- Continuation of coverage ceases immediately at the earliest of the following dates: (1) the Covered Person returns to work; (2) the Plan terminates; (3) the Covered Person's job is eliminated; (4) the Covered Person's employment terminates.

COVERAGE DETAIL

Requirements to Receive LTD Payments

To receive LTD payments, none of the exclusions listed in this SPD, below, may apply and you must:

- Meet the eligibility requirements (see Eligibility and Participation, below);
- Have been Disabled before January 1, 2010 (see Definitions, below); and
- Have completed the Elimination Period (see Definitions, below).

Amount of LTD Benefits

The amount of your LTD benefit is equal to 50% of your Basic Monthly Earnings except that your Monthly Benefit cannot be more than $20,000 per month, and then reduced by Other Income Benefits and Other Income Earnings as described below.

<u>Prorated Benefits</u>

For any period for which a Plan benefit is payable that does not extend through a full month, the benefit is paid on a prorated basis. The rate will be 1/30th for each day for such period of Disability.

LTD Benefits Reduced by Other Income Benefits and Other Income Earnings

Your LTD benefit is reduced by Other Income Benefits and Other Income Earnings. Other Income Benefits means:

1. The amount for which the Covered Person is eligible under:
    - Workers' or Workmen's Compensation Laws;
    - Occupational Disease Law;
    - Title 46, United States Code Section 688 (The Jones Act);
    - any work loss provision in mandatory "No-Fault" auto coverage;
    - Railroad Retirement Act;
    - any governmental compulsory benefit act or law; or
    - any other act or law of like intent.
2. The amount of any Disability benefits which the Covered Person is eligible to receive under:
    - any group short term disability or other long term disability plan of the Plan Sponsor;
    - any governmental retirement system as a result of their employment with the Employer; or
    - any individual short term disability or long term disability plan where the premium is or was wholly or partially paid by the Plan Sponsor. However, the Plan will only reduce the Monthly Benefit if the Covered Person's Monthly Benefit under this Plan, plus any benefits that the Covered Person is eligible to receive under such individual coverage plan exceed 100% of the Covered Person's Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, the Covered Person's Monthly Benefit under this plan is reduced by such excess amount.
3. The amount of Disability Benefits the Covered Person receives under a Retirement Plan, such as the Rohm and Haas Company Retirement Plan.
4. The amount of Disability and/or Retirement Benefits the Covered Person receives or is eligible to receive under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.
5. Any amount the Covered Person receives from any unemployment benefits.

Other Income Earnings means:

1. Any amount the Covered Person receives from any formal or informal sick leave or salary continuation plan(s) or payroll practice; and
2. The amount of earnings the Covered Person earns or receives from any form of employment including severance.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Plan pays a benefit. The sum of Other Income Benefits and Other Income Earnings are deducted from benefits payable under the Plan. The Plan reduces the Covered Person's Disability or Partial Disability benefits by the amount of Other Income

Benefits that the Plan estimates are payable to the Covered Person and their dependents. However, the Covered Person's Disability benefit is not be reduced by the estimated amount of Other Income Benefits if the Covered Person:

- provides satisfactory proof of application for Other Income Benefits;
- signs a reimbursement agreement under which, in part, the Covered Person agrees to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;
- if applicable, provides satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and
- if applicable, submits satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

The Plan will not estimate or reduce for any benefits under the Plan Sponsor's pension or retirement benefit plan, until the Covered Person actually receives them.

In the event that the Plan overestimates the amount payable to the Covered Person from any plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse the Covered Person for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgment) or denied (after appeal through the highest administrative level).

The Plan Administrator may help a Covered Person in applying for Social Security Disability Income Benefits. In order to be eligible for assistance the Covered Person must be receiving a Monthly Benefit from the Plan. Such assistance will be provided only if the Plan determines that assistance would be beneficial to the Plan.

Lump Sum Payments

Your LTD Plan benefit also is reduced by Other Income Benefits from a compromise, settlement, award or judgment which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:

- loss of past or future wages;
- impaired earnings capacity;
- lessened ability to compete in the open labor market;
- any degree of permanent impairment; and
- any degree of loss of bodily function or capacity.

For lump sum payments, your LTD benefit reduction is prorated on a monthly basis as follows:

- Over the period of time such benefits would have been paid if not in a lump sum; or

- If such period of time cannot be determined, the lesser of (1) the remainder of the Maximum Benefit Period, or (2) 5 years.

Cost of Living Freeze

After the first deduction for each of the Other Income Benefits, the Monthly Benefit is not further reduced due to any cost of living increases payable under the Other Income Benefits and Other Income Earnings provision of this Plan. This provision does not apply to increases received from any form of employment.

Maximum Benefit Period

A Covered Person's LTD payments may not exceed the maximum benefit period described below. The LTD payments may terminate prior to the maximum benefit period if any of the reasons for discontinuance of the LTD benefits described below apply.

AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
LESS THAN AGE 60	To the greater of SSNRA* or age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 AND OVER	12 months

*SSNRA refers to the Social Security Normal Retirement Age, as determined by the 1983 amendment to the Social Security Act and any subsequent amendments thereto, as follows:

YEAR OF BIRTH	SSNRA
BEFORE 1938	65
1938	65 and 2 months
1939	65 and 4 months

1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 AND AFTER	67

Proof of Disability and Continuing Proof of Disability

If you filed a claim for disability payments, you must have provided proof that you had a qualifying Disability or Partial Disability as defined under the Plan. This proof must have been provided no later than 30 days after the end of the 365-day Elimination Period, at your own expense.

Once you are being paid monthly LTD Plan benefits, the Claims Administrator has the right to request proof of a qualifying disability as often as it reasonably chooses. In general, you must provide proof, at your own expense, of the qualifying disability within 30 days of the Claims Administrator's request for such proof.

LTD Plan benefits are not payable if you failed to provide satisfactory proof of a qualifying disability when you filed an LTD claim, or later when the Claims Administrator asks for it; nor are Plan benefits payable for any period of time during which you are not under the care of a Physician for the disability.

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

A decision by your employer that you cannot perform the essential functions of your job with or without reasonable accommodation is independent of the Claims Administrator’s decision as to whether you meet the definition of a qualifying disability, and is based on different criteria and requirements of proof than the qualifying disability determination by the Claims Administrator.

In determining whether the Covered Person is Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Disabled due to Injury or Sickness and requires the Regular Attendance of a Physician, the Plan will pay the Covered Person a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person provides the Claims Administrator proof of:

- Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

For purposes of determining Disability, the Injury or Sickness must occur and Disability must begin while the Employee is covered under the Plan.

Working While Disabled: Partial Disability

If you become Partially Disabled while you are covered under the Plan, you may qualify for partial disability benefits as long as you are able to prove your continued Disability and as long as work that meets your accommodation needs (as determined by a medical professional) is available to you.

Proof of Partial Disability must be given upon the Claims Administrator’s request and at the Covered Person’s expense. In determining whether the Covered Person is Partially Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Partially Disabled and has experienced a loss of earnings due to Injury or Sickness and requires the Regular Attendance of a Physician, he may be eligible to receive a Monthly Benefit, subject to any other provisions of the Plan. To be eligible to receive Partial Disability benefits, the Covered Person may be

employed in their Own Occupation or another occupation, must satisfy the Elimination Period and must be earning between 20% and 80% of their Basic Monthly Earnings.

A Monthly Benefit will be paid for the period of Partial Disability if the Covered Person gives to the Claims Administrator Proof of continued:

- Partial Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

The Proof must be given upon the Claims Administrator's request and at the Covered Person's expense.

For purposes of determining Partial Disability, the Injury must have occurred and the Partial Disability must have begun while you were covered under the Plan.

Partial Disability Benefit Amount

For the first 12 months, the work incentive benefit will be an amount equal to the Covered Person's Basic Monthly Earnings multiplied by the benefit percentage shown in the Plan specifications, without any reductions from earnings. The work incentive benefit will be reduced only if the Monthly Benefit payable plus any earnings exceed 100% of the Covered Person's Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus the Covered Person's earnings does not exceed 100% of their Basic Monthly Earnings.

Thereafter, the Monthly Benefit will be calculated as follows:

- First, subtract from the Covered Person's Basic Monthly Earnings the Covered Person's earnings received while he is Partially Disabled. (This figure represents the amount of lost earnings.);
- Second, multiply the amount of lost earnings by 75%; and
- Third, deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from the amount calculated in the second step.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to the Plan, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

Three Month Survivor Benefit

The Plan will pay a lump sum benefit to the Eligible Survivor when Proof is received that a Covered Person died after their Disability had continued for 180 or more consecutive days and while he was receiving a Monthly Benefit. The lump sum benefit will be an amount equal to three times the Covered Person's Last Monthly Benefit.

If the survivor benefit is payable to the Covered Person's children, payment is made in equal shares to the children, including step-children and legally adopted children. However, if any of said children are minors or incapacitated, payment is made on the children's behalf to the court appointed guardian of the property. This payment is valid and effective against all claims by others representing or claiming to represent the children.

If there is no Eligible Survivor, the benefit is payable to the estate.

If an overpayment is due to the Plan at the time of a Covered Person's death, the benefit payable under this provision is applied toward satisfying the overpayment.

Discontinuation of the Long Term Disability Benefit

The Monthly Benefit ceases on the earliest of the date on which the Covered Person:

1. Fails to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;
2. Fails to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
3. Refuses to be examined or evaluated at reasonable intervals;
4. Refuses to receive Appropriate Available Treatment;
5. Refuses a job with the Employer where workplace modifications or accommodations were made to allow the Covered Person to perform the Material and Substantial Duties of the job;
6. Is able to work in their Own Occupation on a part-time basis, but chooses not to;
7. Has current Partial Disability earnings that exceed 80% of their Basic Monthly Earnings. (For these purposes, the Plan averages earnings over three consecutive months rather than immediately terminating their benefit once 80% of Basic Monthly Earnings has been exceeded.);
8. Is no longer Disabled or Partially Disabled according to this Plan;
9. Reaches the end of the Maximum Benefit Period;
10. Dies;
11. Retires; or
12. Quits employment.

What LTD Does Not Cover

LTD benefits under the Plan are not paid unless you were a Covered Person, satisfied the Elimination Period requirement, met the definition of Disability or Partial Disability before

January 1, 2010, and are under the care of a Physician. No benefits are paid during periods of incarceration or imprisonment. In addition, no benefits are payable from the Plan for Disabilities or Partial Disabilities due to:

- Any war (declared or undeclared) or act of war;
- Intentionally inflicted injuries while sane or insane;
- Active participation in a riot;
- A pre-existing condition (see Pre-Existing Condition Exclusion);
- Your committing, or attempt to commit, a felony or misdemeanor; or
- Cosmetic surgery, unless in connection with an injury or illness sustained while covered under the LTD Plan.

To Whom LTD Payments are Paid

In general, the Plan benefit is payable only to the Covered Person. However, if a benefit is payable to a Covered Person's estate or to a Covered Person who is not competent, the Plan has the right to pay up to $2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Termination of a Covered Person's Coverage

A Covered Person ceases to be covered under the Plan on the earliest of the following dates:

- the date the Plan terminates, but without prejudice to any claim originating prior to the time of termination;
- the date the Covered Person is no longer a full-time or part-time bargained-for Employee of Rohm and Haas Company whose primary work location is Kilbourn;
- the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the coverage will be continued for an Employee absent due to Disability during the Elimination Period; or
- the date the Covered Person ceases active work due to a labor dispute, including any strike, work slowdown, or lockout.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Exclusion

The Plan does not cover any Disability or Partial Disability which:

- is caused or contributed to by, or results from, a Pre-Existing Condition; and
- begins in the first 12 months immediately after the Covered Person's effective date of coverage.

Pre-Existing Condition means a condition resulting from an Injury or Sickness for which the Covered Person is diagnosed or received Treatment within three months prior to the Covered Person's effective date of coverage.

Mental Illness and/or Substance Abuse Limitation

The benefit for disability due to Mental Illness and/or Substance Abuse will not exceed a combined period of 24 months of monthly benefit payments while you are covered under the Plan; however, if you are in a Hospital or Institution for Mental Illness and/or Substance Abuse at the end of the combined period of 24 months, the monthly benefit will continue to be paid during the period of your confinement.

If you are not confined in a Hospital or Institution for Mental Illness and/or Substance Abuse, but are fully participating in an extended treatment plan for the condition that caused your Disability, the monthly benefit will be payable to you for up to a combined period of 36 months.

ANCILLARY BENEFITS

If you are receiving benefit payments under the Plan, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits are not provided under the Plan. Instead, the terms of the ancillary benefit plans may extend eligibility to you because of your status under the Plan.

The following information is provided here only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern.

BENEFIT COVERAGE	WHAT HAPPENS TO COVERAGE WHILE ON AN APPROVED DISABILITY
EMPLOYEE PURCHASED LIFE INSURANCE	You are eligible for coverage while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work, and you must make timely premium contributions in order to continue coverage.
REIMBURSEMENT ACCOUNTS (HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT(DCFSA))	You may not continue to make contributions to DCFSA or HCFSA while you are receiving LTD payments.
MEDICAL AND DENTAL INSURANCE	In general, you are eligible to continue coverage for yourself and your eligible dependents under The Dow Chemical Company Medical Care Program,

	The Dow Chemical Company Dental Assistance Program and/or The Dow Chemical Company Insured Health Program, while you are receiving Plan benefit payments, as long as you continue to make any required contributions. Refer to the summary plan descriptions for those programs for more information. You may qualify for Social Security disability benefits, or you may be eligible for Medicare. Ask your local Social Security office for details.
MEDICARE	If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (FORMERLY PAI)	You are eligible for accidental, death and dismemberment insurance while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work and you must make timely premium contributions.
COMPANY-PAID LIFE INSURANCE	You are eligible for company-paid life insurance coverage while you are receiving Plan benefit payments.
SERVICE CREDIT	You do not continue to accumulate benefit service while you are receiving Plan benefit payments.
TRAVEL ACCIDENT INSURANCE AND OCCUPATIONAL ACCIDENT INSURANCE	Travel accident and occupational accident insurance coverage (such as through Dow's BTA/OAI Plan) stops when you begin receiving Plan benefit payments.

VACATION TIME	Vacation time cannot be taken while you are receiving Plan benefit payments. If you are on partial disability status, your vacation accruals will remain the same as during your pre-disability period through the end of the calendar year in which your partial disability status commenced. Beginning January 1 of the subsequent calendar year, your vacation accrual will be based on your working hours in that year (assuming you remain in partial disability status).
HOLIDAYS	A Holiday is considered a regular work day when calculating disability benefits.
401(K) PLAN	In general, you may leave your account in the 401(k) plan until April 1st after you reach age 701/2. If you have a loan(s), you must continue to repay the loan. If no loan payments are made and you do not return to work within one year, your loan defaults.
PENSION PLAN	In general, you continue to earn service credit under the Rohm and Haas Company Retirement Plan while you are receiving Plan benefit payments.

SUBROGATION

As used in this Appendix these terms have the following meaning:

- "Covered Person" means a participant in the Plan, the parents and legal guardians of a participant who is a minor, and the heirs, administrators, and executors of a participant's estate.
- "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition, without regard to whether such party caused the illness, injury, or condition. The term "Responsible Party" includes the liability insurer of such party, any Insurance Coverage, and any employer, agent, or principal of such party.
- "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

The Plan's Entitlement to Reimbursement

Subrogation. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to the Covered Person's injury, illness or condition to the full extent of benefit provided or to be provided by the Plan.

Reimbursement. If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition (including attorneys' fees and other costs incurred in enforcing the Plan's rights), up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits from the Plan, the Covered Person agrees that if they receive any payment from any Responsible Party as a result of an injury, illness or condition, they will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan, and the Plan may pursue equitable remedies to recover the monies or withhold future benefits until reimbursement is made.

Lien Rights. The Plan will automatically have a lien to the extent of benefits paid by the Plan for which the Responsible Party is alleged to be liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; the Responsible Party, the Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim. By accepting benefits from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Third Parties and are to be paid to the Plan before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Plan is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make them whole (i.e., the "make whole" doctrine will not apply).

Applicability to All Settlements and Judgments. The Plan is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only (i.e., the "common fund" doctrine will not apply).

Plan Not Required to Pay Court Costs or Attorneys' Fees. The Plan is not required to participate in or pay court costs or attorneys' fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim. Should it be necessary for the Plan to institute legal action against a Covered Person (or assignee) for failure to reimburse the Plan in full, or for failure to honor the Plan's equitable interest in the amount recovered from a Responsible Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys' fees.

Your Responsibilities

The Covered Person is required to fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and their agent shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. The rights described in this Appendix are assigned to the Plan without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Plan an assignment and other instruments that may be used to facilitate securing the rights of the Plan. The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the Plan's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Plan may withhold future benefits or terminate the Participant and the Covered Person from the Plan if the Covered Person does not fully cooperate with the Plan's efforts to recover the benefits paid by the Plan. In addition, if the Participant or the Covered Person is terminated from eligibility under any benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of failure to reimburse that benefit plan, the Plan Administrator may determine that the Participant and/or the Covered Person are disqualified from eligibility for coverage under the Plan.

The Covered Person acknowledges by accepting benefits from the Plan that the Plan has the right to conduct an investigation regarding the injury, illness or condition in order to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and their agent of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Covered Person's obligation to reimburse the Plan is limited to the amount of benefits the Plan has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. However, if the Plan must institute a legal action because a Covered Person fails to reimburse the Plan in full or to honor the Plan's equitable interest in any recovery, the Covered person will be liable for all costs of collection, including reasonable attorneys' fees.

If the Plan has overpaid you any overpayments made to you may be offset by the Plan in future payments or claims.

Jurisdiction

For purposes of this Section 6, by accepting benefits from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of their present or future domicile.

Overpayments

Whenever a disability payment is made under the Plan, the Claims Administrator has the right to recover any overpayments (including Survivor Benefits), whether due to fraud, an error in processing a claim, or your receipt of other sources of income. You will be required to reimburse the Claims Administrator for the full amount of the overpayment. The method by which the repayment is made will be determined by the Claims Administrator (this repayment will never exceed the benefit amount paid to you by the Plan). Required reimbursements must be satisfied before Plan benefits may continue.

Workers Compensation

This Plan and the Plan coverage provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

ADDITIONAL FUNDING INFORMATION

Dow pays the entire cost of the Plan from its general assets.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for Plan Benefits - Lincoln is both the Initial Claims Reviewer for Claims for Plan Benefits and the Appeals Administrator for denied Claims for Plan Benefits.

Time Limitation for Filing a Claim and Filing Proof of Claim

Claims for Plan Benefits - In general, you must have filed a Claim for Plan Benefits within 30 days after the date your qualifying disability begins, and you must have filed your proof of the Disability within 30 days of the request for such proof; otherwise your Claim for Plan Benefits will be denied (unless there are extenuating circumstances as determined by the Claims Administrator).

Claims for Eligibility Determinations - You must have filed a Claim for an Eligibility Determination no later than 30 days after your last day on the payroll of Dow.

Proof of Disability

If you are being paid monthly LTD benefits, the Claims Administrator has the right to request proof of Disability or Partial Disability as often as it reasonably chooses. Monthly Benefits will not be paid with respect to your Disability or Partial Disability if you fail to provide proof that is

satisfactory to Lincoln when you file an LTD claim, or later when Lincoln asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Disability.

Claims for Plan Benefits

To submit a Claim for Plan benefits, you must complete a claim form and provide documentation showing that you were Totally Disabled during and for the time required under the Plan. Contact the HR Service Center at:

North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674

Attention: Plan Administrator for Rohm and Haas Long Term Disability Program - Kilbourn

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

Group Benefits Disability Claims
Lincoln National Life Insurance Company
P.O. Box 7211
London, KY 40742-7211

Initial Determination

When you submit a Claim for disability benefits to Lincoln, 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 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 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 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 Initial Claims Reviewer's sole discretion, 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 will decide the claim without the additional information.

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

- The specific reason or reasons for denial of the claim;

- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary;
- 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;
- 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;
- An explanation of the Plan's appeal procedures and the applicable time limits; and
- 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 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 the Initial Claims Reviewer's notice of denial, assuming that there are not extenuating circumstances, as determined by the Appeals Administrator, 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
- Explanation of the reason why you are appealing the Initial Determination Send your appeal to:
- Group Benefits Disability Claims
  Lincoln National Life Insurance Company
  P.O. Box 7211
  London, KY 40742-7211
  Attention: Claims Administrator for Rohm and Haas Long Term Disability Program (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 Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator under applicable federal regulations. Your request must be in writing. Such information will be provided at no cost to you.

General Business

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 take into account all comments, documents, records, etc. submitted to the Appeals Administrator that is related to the Claim without regard to whether such information was submitted or considered in the initial determination. The Appeals Administrator will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator 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 may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

The Appeals Administrator 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 may have up to an additional 45 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 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 Appeals Administrator's sole discretion, 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 will decide the Claim

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

- The specific reason(s) why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement 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;
- If an adverse decision is based on advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- 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;
- 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;

- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- A statement of your right to bring a civil action under section 502(a) of ERISA.

ADDITIONAL DEFINITIONS

"Active Employment" means the Employee must be actively at work for the Employer on a full-time or part-time basis and paid regular earnings and perform such work either (1) at the Employer's usual place of business, or (2) at a location to which the Employer's business requires the Employee to travel.

An Employee will be considered actively at work if he was actually at work on the day immediately preceding a weekend (except where one or both of these days are scheduled work days); a holiday (except when the holiday is a scheduled work day); a paid vacation; any non-scheduled work day; an excused leave of absence (except medical leave for the Covered Person's own disabling condition, voluntary leave of absence in lieu of lay-off and lay-off); and an emergency leave of absence (except emergency medical leave for the Covered Person's own disabling condition).

"Any Occupation" means any occupation that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Benefits, Lincoln, and, with respect to reviewing an adverse Claim for an Eligibility Determination, the Global Benefits Director and the Associate Director of North America Benefits for The Dow Chemical Company.

"Appropriate Available Treatment" means care or services which are:

- generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within the Covered Person's geographical region;
- provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
- in accordance with generally accepted medical standards of practice.

"Basic Monthly Earnings" means the Covered Person's monthly rate of earnings from the Employer in effect immediately prior to the date Disability or Partial Disability begins, up to a maximum of $40,000 per month. Such earnings will not include bonuses, commissions, overtime pay and extra compensation.

"Covered Person" means an Employee covered under this Plan. "Disability" or "Disabled" means as follows:

- For persons other than pilots, co-pilots, and crewmembers of an aircraft, "Disability" or "Disabled" means:
  - during the Elimination Period and the next 24 months of Disability the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of their Own Occupation; and
  - Thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.
  - With respect to Covered Persons employed as pilots, co-pilots and crewmembers of an aircraft, "Disability" or "Disabled" means as a result of Injury or Sickness the Covered Person is unable to perform the Material and Substantial Duties of Any Occupation.

"Disability Benefits under a Retirement Plan" means money which:

- is payable under a Retirement Plan due to Disability as defined in that plan; and
- does not reduce the amount of money which would have been paid as Retirement Benefits at the normal retirement age under the plan if the Disability had not occurred. (If the payment does cause such a reduction, it will be deemed a Retirement Benefit as defined in this Plan.)

"Eligibility Date" means the date an Employee becomes eligible for coverage under this Plan.

"Eligible Survivor" means the Covered Person's spouse or Domestic Partner, if living, otherwise the Covered Person's children under age 25.

"Elimination Period" means a period of consecutive days of Disability or Partial Disability for which no benefit is payable. The Elimination Period is the greater of either (1) the period the Covered Person receives Short Term Disability benefits, salary continuation, or pay from a payroll practice, or any combination thereof, or (2) 180 days.

If the Covered Person returns to work for any 14 or fewer days during the Elimination Period and cannot continue, the Plan Administrator will count only those days the Covered Person is Disabled or Partially Disabled to satisfy the Elimination Period.

"Employer" means Rohm and Haas Company and its Participating Employers.

"Extended Treatment Plan" means continued care that is consistent with the American Psychiatric Association's standard principles of Treatment, and is in lieu of confinement in a Hospital or Institution. It must be approved in writing by a Physician.

"Family and Medical Leave" means a leave of absence for the birth, adoption or foster care of a child, or for the care of the Covered Person's child, spouse or parent or for the Covered

Person's own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"Hospital" or "Institution" means a facility licensed to provide Treatment for the condition causing the Covered Person's Disability.

"Initial Claims Reviewer" means, with respect to deciding Claims for Plan Benefits, Lincoln, and, with respect to deciding a Claim for an Eligibility Determination, the North America Health and Welfare Plans Leader for The Dow Chemical Company.

"Injury" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

- any Disability which begins more than 60 days after an Injury will be considered a Sickness; and
- any Injury which occurs before the Covered Person is covered under this Plan, but which accounts for a medical condition that arises while the Covered Person is covered under this Plan will be treated as a Sickness.

"Last Monthly Benefit" means the Monthly Benefit payable to the Covered Person prior to their death without any reduction for earnings received from employment.

"Lincoln" means Lincoln National Life Insurance Company, 100 Liberty Way, Dover, New Hampshire 03820.

"Material and Substantial Duties" means responsibilities that are normally required to perform the Covered Person's Own Occupation, or any other occupation, and cannot be reasonably eliminated or modified.

"Mental Illness" means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, the Sponsor will use the replacement chosen or published by the American Psychiatric Association.

"Monthly Benefit" means the monthly amount payable by the Plan Sponsor to the Disabled or Partially Disabled Covered Person.

"Own Occupation" means the Covered Person's occupation that he was performing when their Disability or Partial Disability began. For the purposes of determining Disability under this Plan, the Plan will consider the Covered Person's occupation as it is normally performed in the national economy.

"Partial Disability" or "Partially Disabled" means the Covered Person, as a result of Injury or Sickness, is able to:

- perform one or more, but not all, of the Material and Substantial Duties of their Own Occupation or Any Occupation on an Active Employment or a part-time basis; or

- perform all of the Material and Substantial Duties of their Own Occupation or Any Occupation on a part-time basis; and
- earn between 20% and 80% of their Basic Monthly Earnings.

“Physician” means a person who:

- is licensed to practice medicine and is practicing within the terms of their license; or
- is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of their license.

Physician does not include a Covered Person, any family member or domestic partner.

“Proof” means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

- a claim form completed and signed (or otherwise formally submitted) by the Covered Person claiming benefits;
- an attending Physician’s statement completed and signed (or otherwise formally submitted) by the Covered Person’s attending Physician; and
- the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a form or format satisfactory to the Plan Administrator and Lincoln.

“Regular Attendance” means the Covered Person’s personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat the Covered Person’s Disability or Partial Disability.

“Retirement Benefit under a Retirement Plan” means money which:

- is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee’s expected remaining life regardless of when such payments are actually received); and
- is payable upon:
    - early or normal retirement; or
    - Disability, if the payment does reduce the amount of money which would have been paid under the plan at the normal retirement age.

“Retirement Plan” means a plan, such as the Rohm and Haas Company Retirement Plan, which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, informal salary continuation plan,

registered retirement savings plan, stock ownership plan, 401(K) or a non-qualified plan of deferred compensation.

"Sickness" means illness, disease, pregnancy or complications of pregnancy.

"Substance Abuse" means alcohol and/or drug abuse, addiction, or dependency.

"Treatment" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the Covered Person chooses to take them or not, and taking drugs and/or medicines.

25.5 Long Term Disability 5

Former SPD Name:	Rohm and Haas Company Health and Welfare Plan's Disability Program's Long Term Disability Program (applicable to closed population of Bargained-For employees at Philadelphia, Louisville, Bristol / Croydon, Knoxville, Houston sites Whose Disability began before January 1, 2010)
Legal Plan Name:	The Rohm and Haas Company Health and Welfare Plan
Legal Plan Number:	Plan 551
Claims Administrators for Claims for Plan Benefits:	Lincoln Group Benefits Disability Claims Lincoln National Life Insurance Company P.O. Box 7211 London, KY 40742-7211

ADDITIONAL ELIGIBILITY INFORMATION

If your Disability began on or after January 1, 2010, you are not eligible for the Plan, but you may contact the Dow Retiree Service Center to see whether you qualify under The Dow Chemical Company Long Term Disability Plan.

Eligible Employees

The Plan applies only to eligible bargained-for Employees of Rohm and Haas Company or a Participating Employer whose qualifying Disability or Partial Disability occurred before January 1, 2010. You are eligible for coverage under the Plan if:

- You were a bargained-for Employee of Rohm and Haas Company or a Participating Employer whose regular work schedule was a minimum of 40 hours per week;
- You were in Active Employment before January 1, 2010;
- Your Disability began before January 1, 2010; and
- Your primary work location was one of the following sites:

  Philadelphia, PA Knoxville, TN Louisville, KY

  Bristol/Croydon, PA Houston, TX

The definition of "Employee" does not include temporary employees (regardless of whether you are eligible for any other benefit), seasonal employees, leased employees, independent contractors, any person designated by Rohm and Haas Company or a Participating Employer at the time of hire as not eligible to participate in the Plan, even if such ineligible person is

subsequently determined to be an "employee" by any government or judicial authority, or any member of a group or class not eligible for benefits as designated by the Employer.

Eligibility Waiting Period

If you were an Eligible Employee, you were automatically enrolled in the Plan once you satisfied the Eligibility Waiting Period. You satisfied the Eligibility Waiting Period by being in Active Employment for 3 months. Once covered under the Plan, you were a "Covered Person."

Family and Medical Leave

If you were a Covered Person and your qualifying Disability occurred prior to January 1, 2010, you were permitted to continue coverage under this Plan if you were on an approved family or medical leave of absence for up to 12 weeks following the date coverage would have otherwise terminated, subject to the following:

- The authorized leave must have been in writing.
- The Covered Person's benefit level, or the amount of earnings upon which the Covered Person's benefit may be based, is that in effect on the date before such leave began.
- Continuation of coverage ceases immediately at the earliest of the following dates: (1) the Covered Person returns to work; (2) the Plan terminates; (3) the Covered Person's job is eliminated; (4) the Covered Person's employment terminates.

COVERAGE DETAIL

Requirements to Receive LTD Payments

To receive LTD payments, none of the exclusions listed in this SPD, below, may apply and you must:

- Meet the eligibility requirements (see Eligibility and Participation, below);
- Have been Disabled before January 1, 2010 (see Definitions, below); and
- Have completed the Elimination Period (see Definitions, below).

Amount of LTD Benefits

In general, the amount of your LTD benefit is equal to 50% of your Basic Monthly Earnings, reduced by Other Income Benefits and Other Income Earnings as described below.

However, if you are eligible for the DRA formula, then your LTD benefit equals the greater of (1) 50% of your Basic Monthly Earnings, reduced by Other Income Benefits and Other Income Earnings, or (2) the DRA formula, reduced by Other Income Benefits and Other Income Earnings. The DRA formula is based on the amount your pension benefit would be if you were to commence your pension under the Rohm and Haas Company Retirement Plan at normal retirement age using your base pay and length of service at the time your qualifying Disability started. The DRA formula is a formula borrowed by the Plan from the Rohm and Haas Company

Retirement Plan and is calculated by Dow. The Rohm and Haas Company Retirement Plan does not pay the benefit or provide any amount of the benefit under the DRA formula.

Eligibility for DRA Formula

In order to qualify for the DRA formula, you must have been eligible to receive an LTD monthly benefit and you must:

- Have had five (5) years of service under the Rohm and Haas Company Retirement Plan at the time your Disability began;
- Have met the definition of Disabled as applicable to DRA (see the Definitions in this Appendix); and
- Have received Social Security disability benefits for at least seven months.

Prorated Benefits

For any period for which a Plan benefit is payable that does not extend through a full month, the benefit is paid on a prorated basis. The rate will be 1/30th for each day for such period of Disability.

LTD Benefits Reduced by Other Income Benefits and Other Income Earnings

Your LTD benefit is reduced by Other Income Benefits and Other Income Earnings. Other Income Benefits means:

1. The amount for which the Covered Person is eligible under:
    - Workers' or Workmen's Compensation Laws;
    - Occupational Disease Law;
    - Title 46, United States Code Section 688 (The Jones Act);
    - any work loss provision in mandatory "No-Fault" auto coverage;
    - Railroad Retirement Act;
    - any governmental compulsory benefit act or law; or
    - any other act or law of like intent.
2. The amount of any Disability benefits which the Covered Person is eligible to receive under:
    - any group short term disability or other long term disability plan of the Plan Sponsor;
    - any governmental retirement system as a result of their employment with the Employer; or
    - any individual short term disability or long term disability plan where the premium is or was wholly or partially paid by the Plan Sponsor. However, the Plan will only reduce the Monthly Benefit if the Covered Person's Monthly Benefit under this

Plan, plus any benefits that the Covered Person is eligible to receive under such individual coverage plan exceed 100% of the Covered Person's Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, the Covered Person's Monthly Benefit under this plan is reduced by such excess amount.

3. The amount of Disability Benefits the Covered Person receives under a Retirement Plan, such as the Rohm and Haas Company Retirement Plan.

4. The amount of Disability and/or Retirement Benefits the Covered Person receives or is eligible to receive under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.

5. Any amount the Covered Person receives from any unemployment benefits.

Other Income Earnings means:

1. Any amount the Covered Person receives from any formal or informal sick leave or salary continuation plan(s) or payroll practice; and

2. The amount of earnings the Covered Person earns or receives from any form of employment including severance.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Plan pays a benefit. The sum of Other Income Benefits and Other Income Earnings are deducted from benefits payable under the Plan. The Plan reduces the Covered Person's Disability or Partial Disability benefits by the amount of Other Income Benefits that the Plan estimates are payable to the Covered Person and their dependents. However, the Covered Person's Disability benefit is not be reduced by the estimated amount of Other Income Benefits if the Covered Person:

- provides satisfactory proof of application for Other Income Benefits;
- signs a reimbursement agreement under which, in part, the Covered Person agrees to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;
- if applicable, provides satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and
- if applicable, submits satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

The Plan will not estimate or reduce for any benefits under the Plan Sponsor's pension or retirement benefit plan, until the Covered Person actually receives them.

In the event that the Plan overestimates the amount payable to the Covered Person from any plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse the Covered Person for such amount upon receipt of written proof of the

amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgment) or denied (after appeal through the highest administrative level).

The Plan Administrator may help a Covered Person in applying for Social Security Disability Income Benefits. In order to be eligible for assistance the Covered Person must be receiving a Monthly Benefit from the Plan. Such assistance will be provided only if the Plan determines that assistance would be beneficial to the Plan.

Lump Sum Payments

Your LTD Plan benefit also is reduced by Other Income Benefits from a compromise, settlement, award or judgment which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:

- loss of past or future wages;
- impaired earnings capacity;
- lessened ability to compete in the open labor market;
- ·any degree of permanent impairment; and
- any degree of loss of bodily function or capacity.

For lump sum payments, your LTD benefit reduction is prorated on a monthly basis as follows:

- Over the period of time such benefits would have been paid if not in a lump sum; or
- If such period of time cannot be determined, the lesser of (1) the remainder of the Maximum Benefit Period, or (2) 5 years.

Cost of Living Freeze

After the first deduction for each of the Other Income Benefits, the Monthly Benefit is not further reduced due to any cost of living increases payable under the Other Income Benefits and Other Income Earnings provision of this Plan. This provision does not apply to increases received from any form of employment.

Maximum Benefit Period

A Covered Person's LTD payments may not exceed the maximum benefit period described below. The LTD payments may terminate prior to the maximum benefit period if any of the reasons for discontinuance of the LTD benefits described below, apply.

If You Had Fewer Than 5 Years of Service When Your Disability or Partial Disability Began

If you had less than 5 years of service when your Disability or Partial Disability began, your benefit period is equal to your completed months of Active Employment at the time your Disability or Partial Disability began, less any months for which you previously received Long Term Disability Benefits.

If You Had 5 or More Years of Service When Your Disability or Partial Disability Began

If you had 5 or more years of service when your Disability or Partial Disability began, your Plan benefits are paid until the earliest of the following events:

- when you return to work;
- your retirement; or
- your attainment of age 65.

If You Were Age 61 or Older When Your Disability or Partial Disability Began

If you were age 61 or older when your Disability or Partial Disability began, any Long Term Disability Plan benefits will be paid until the earlier of receiving a Retirement Benefit under a Retirement Plan or as follows:

AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
LESS THAN AGE 62	To age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 AND OVER	12 months

Proof of Disability and Continuing Proof of Disability

If you filed a claim for disability payments, you must have provided proof that you had a qualifying Disability or Partial Disability as defined under the Plan. This proof must have been provided no later than 30 days after the end of the 365-day Elimination Period, at your own expense.

Once you are being paid monthly LTD Plan benefits, the Claims Administrator has the right to request proof of a qualifying disability as often as it reasonably chooses. In general, you must provide proof, at your own expense, of the qualifying disability within 30 days of the Claims Administrator's request for such proof.

LTD Plan benefits are not payable if you failed to provide satisfactory proof of a qualifying disability when you filed an LTD claim, or later when the Claims Administrator asks for it; nor

are Plan benefits payable for any period of time during which you are not under the care of a Physician for the disability.

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

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

In determining whether the Covered Person is Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Disabled due to Injury or Sickness and requires the Regular Attendance of a Physician, the Plan will pay the Covered Person a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person provides the Claims Administrator proof of:

- Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

For purposes of determining Disability, the Injury or Sickness must occur and Disability must begin while the Employee is covered under the Plan.

Working While Disabled: Partial Disability

If you become Partially Disabled while you are covered under the Plan, you may qualify for partial disability benefits as long as you are able to prove your continued Disability and as long as work that meets your accommodation needs (as determined by a medical professional) is available to you.

Proof of Partial Disability must be given upon the Claims Administrator's request and at the Covered Person's expense. In determining whether the Covered Person is Partially Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Partially Disabled and has experienced a loss of earnings due to Injury or Sickness and requires the Regular Attendance of a Physician, he may be eligible to receive a Monthly Benefit, subject to any other provisions of the Plan. To be eligible to receive Partial Disability benefits, the Covered Person may be employed in their Own Occupation or another occupation, must satisfy the Elimination Period and must be earning between 20% and 80% of their Basic Monthly Earnings.

A Monthly Benefit will be paid for the period of Partial Disability if the Covered Person gives to the Claims Administrator Proof of continued:

- Partial Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

The Proof must be given upon the Claims Administrator's request and at the Covered Person's expense.

For purposes of determining Partial Disability, the Injury must have occurred and the Partial Disability must have begun while you were covered under the Plan.

Partial Disability Benefit Amount

For the first 12 months, the work incentive benefit will be an amount equal to the Covered Person's Basic Monthly Earnings multiplied by the benefit percentage shown in the Plan specifications, without any reductions from earnings. The work incentive benefit will be reduced only if the Monthly Benefit payable plus any earnings exceed 100% of the Covered Person's Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus the Covered Person's earnings does not exceed 100% of their Basic Monthly Earnings.

Thereafter, the Monthly Benefit will be calculated as follows:

- First, subtract from the Covered Person's Basic Monthly Earnings the Covered Person's earnings received while he is Partially Disabled. (This figure represents the amount of lost earnings.);
- Second, multiply the amount of lost earnings by 75%; and

- Third, deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from the amount calculated in the second step.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to the Plan, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

Three Month Survivor Benefit

The Plan will pay a lump sum benefit to the Eligible Survivor when Proof is received that a Covered Person died after their Disability has continued for 180 or more consecutive days and while he was receiving a Monthly Benefit. The lump sum benefit will be an amount equal to three times the Covered Person's Last Monthly Benefit.

If the survivor benefit is payable to the Covered Person's children, payment is made in equal shares to the children, including step-children and legally adopted children. However, if any of said children are minors or incapacitated, payment is made on the children's behalf to the court appointed guardian of the property. This payment is valid and effective against all claims by others representing or claiming to represent the children.

If there is no Eligible Survivor, the benefit is payable to the estate.

If an overpayment is due to the Plan at the time of a Covered Person's death, the benefit payable under this provision is applied toward satisfying the overpayment.

Discontinuation of the Long Term Disability Benefit

The Monthly Benefit ceases on the earliest of the date on which the Covered Person:

1. Fails to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;
2. Fails to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
3. Refuses to be examined or evaluated at reasonable intervals;
4. Refuses to receive Appropriate Available Treatment;
5. Refuses a job with the Employer where workplace modifications or accommodations were made to allow the Covered Person to perform the Material and Substantial Duties of the job;
6. Is able to work in their Own Occupation on a part-time basis, but chooses not to;
7. Has current Partial Disability earnings that exceed 80% of their Basic Monthly Earnings. (For these purposes, the Plan averages earnings over three consecutive months rather than

immediately terminating their benefit once 80% of Basic Monthly Earnings has been exceeded.);

8. Is no longer Disabled or Partially Disabled according to this Plan;
9. Reaches the end of the Maximum Benefit Period;
10. Dies;
11. Retires; or
12. Quits employment.

To Whom LTD Payments are Paid

In general, the Plan benefit is payable only to the Covered Person. However, if a benefit is payable to a Covered Person's estate or to a Covered Person who is not competent, the Plan has the right to pay up to $2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Termination of a Covered Person's Coverage

A Covered Person ceases to be covered under the Plan on the earliest of the following dates:

- the date the Plan terminates, but without prejudice to any claim originating prior to the time of termination;
- the date the Covered Person is no longer a full-time or part-time bargained-for Employee of the Employer whose primary work location is either Philadelphia, Louisville, Bristol/Croydon, Knoxville, or Houston (or otherwise meets the eligibility requirements);
- the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the coverage will be continued for an Employee absent due to Disability during the Elimination Period; or
- the date the Covered Person ceases active work due to a labor dispute, including any strike, work slowdown, or lockout.

LIMITATIONS AND EXCLUSIONS

What LTD Does Not Cover

LTD benefits under the Plan are not paid unless you were a Covered Person, satisfied the Elimination Period requirement, met the definition of Disability or Partial Disability before January 1, 2010, and are under the care of a Physician. No benefits are paid during periods of incarceration or imprisonment. In addition, no benefits are payable from the Plan for Disabilities or Partial Disabilities due to:

- Any war (declared or undeclared) or act of war;
- Intentionally inflicted injuries while sane or insane;
- Active participation in a riot;
- A pre-existing condition (see Pre-Existing Condition Exclusion);
- Your committing, or attempt to commit, a felony or misdemeanor; or
- Cosmetic surgery, unless in connection with an injury or illness sustained while covered under the LTD Plan.

Pre-Existing Condition Exclusion

The Plan does not cover any Disability or Partial Disability which:

- is caused or contributed to by, or results from, a Pre-Existing Condition; and
- begins in the first 12 months immediately after the Covered Person's effective date of coverage.

Pre-Existing Condition means a condition resulting from an Injury or Sickness for which the Covered Person is diagnosed or received Treatment within three months prior to the Covered Person's effective date of coverage.

ANCILLARY BENEFITS

If you are receiving benefit payments under the Plan, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits are not provided under the Plan. Instead, the terms of the ancillary benefit plans may extend eligibility to you because of your status under the Plan.

The following information is provided here only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern.

BENEFIT COVERAGE	WHAT HAPPENS TO COVERAGE WHILE ON AN APPROVED DISABILITY
EMPLOYEE PURCHASED LIFE INSURANCE	You are eligible for coverage while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work, and you must make timely premium contributions in order to continue coverage.
REIMBURSEMENT ACCOUNTS (HEALTH CARE FLEXIBLE SPENDING ACCOUNT	You may not continue to make contributions to DCFSA or HCFSA while you are receiving LTD payments.

(HCFSA) AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT(DCFSA))	
MEDICAL AND DENTAL INSURANCE	In general, you are eligible to continue coverage for yourself and your eligible dependents under The Dow Chemical Company Medical Care Program, The Dow Chemical Company Dental Assistance Program and/or The Dow Chemical Company Insured Health Program while you are receiving Plan benefit payments, as long as you continue to make any required contributions. Refer to the summary plan descriptions for those programs for more information. You may qualify for Social Security disability benefits, or you may be eligible for Medicare. Ask your local Social Security office for details.
MEDICARE	If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (FORMERLY PAI)	You are eligible for accidental death and dismemberment insurance while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work and you must make timely premium contributions.
COMPANY-PAID LIFE INSURANCE	You are eligible for company-paid life insurance coverage while you are receiving Plan benefit payments.
SERVICE CREDIT	You do not continue to accumulate benefit service while you are receiving Plan benefit payments.

TRAVEL ACCIDENT INSURANCE AND OCCUPATIONAL ACCIDENT INSURANCE	Travel accident and occupational accident insurance coverage (such as through Dow's BTA/OAI Plan) stops when you begin receiving Plan benefit payments.
VACATION TIME	Vacation time cannot be taken while you are receiving Plan benefit payments. Your vacation accruals will remain the same as during your pre-disability period through the end of the calendar year in which your partial disability status commenced. Beginning January 1 of the subsequent calendar year, your vacation accrual will be based on your working hours in that year (assuming you remain in partial disability status).
HOLIDAYS	A Holiday is considered a regular work day when calculating disability benefits.
401(K) PLAN	In general, you may leave your account in the 401(k) plan until April 1st after you reach age 701/2. If you have a loan(s), you must continue to repay the loan. If no loan payments are made and you do not return to work within one year, your loan defaults.
PENSION PLAN	In general, you continue to earn service credit under the Rohm and Haas Company Retirement Plan while you are receiving Plan benefit payments.

SUBROGATION

As used in this Section these terms have the following meaning:

- "Covered Person" means a participant in the Plan, the parents and legal guardians of a participant who is a minor, and the heirs, administrators, and executors of a participant's estate.
- "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition, without regard to whether such party caused the illness, injury, or condition. The term "Responsible Party" includes the liability insurer of such party, any Insurance Coverage, and any employer, agent, or principal of such party.
- "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

The Plan's Entitlement to Reimbursement

Subrogation. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to the Covered Person's injury, illness or condition to the full extent of benefit provided or to be provided by the Plan.

Reimbursement. If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition (including attorneys' fees and other costs incurred in enforcing the Plan's rights), up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits from the Plan, the Covered Person agrees that if they receive any payment from any Responsible Party as a result of an injury, illness or condition, they will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan, and the Plan may pursue equitable remedies to recover the monies or withhold future benefits until reimbursement is made.

Lien Rights. The Plan will automatically have a lien to the extent of benefits paid by the Plan for which the Responsible Party is alleged to be liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; the Responsible Party, the Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim. By accepting benefits from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Third Parties and are to be paid to the Plan before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Plan is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make them whole (i.e., the "make whole" doctrine will not apply).

Applicability to All Settlements and Judgments. The Plan is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-

economic damages and/or general damages only (i.e., the "common fund" doctrine will not apply).

Plan Not Required to Pay Court Costs or Attorneys' Fees. The Plan is not required to participate in or pay court costs or attorneys' fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim. Should it be necessary for the Plan to institute legal action against a Covered Person (or assignee) for failure to reimburse the Plan in full, or for failure to honor the Plan's equitable interest in the amount recovered from a Responsible Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys' fees.

Your Responsibilities

The Covered Person is required to fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and their agent shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. The rights described in this Appendix are assigned to the Plan without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Plan an assignment and other instruments that may be used to facilitate securing the rights of the Plan. The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the Plan's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Plan may withhold future benefits or terminate the Participant and the Covered Person from the Plan if the Covered Person does not fully cooperate with the Plan's efforts to recover the benefits paid by the Plan. In addition, if the Participant or the Covered Person is terminated from eligibility under any benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of failure to reimburse that benefit plan, the Plan Administrator may determine that the Participant and/or the Covered Person are disqualified from eligibility for coverage under the Plan.

The Covered Person acknowledges by accepting benefits from the Plan that the Plan has the right to conduct an investigation regarding the injury, illness or condition in order to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and their agent of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Covered Person's obligation to reimburse the Plan is limited to the amount of benefits the Plan has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. However, if the Plan must institute a legal action because a Covered Person fails to reimburse the Plan in full or to honor the Plan's equitable interest in any recovery, the Covered person will be liable for all costs of collection, including reasonable attorneys' fees.

If the Plan has overpaid you any overpayments made to you may be offset by the Plan in future payments or claims.

Jurisdiction

For purposes of this Section, by accepting benefits from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of their present or future domicile.

Overpayments

Whenever a disability payment is made under the Plan, the Claims Administrator has the right to recover any overpayments (including Survivor Benefits), whether due to fraud, an error in processing a claim, or your receipt of other sources of income. You will be required to reimburse the Claims Administrator for the full amount of the overpayment. The method by which the repayment is made will be determined by the Claims Administrator (this repayment will never exceed the benefit amount paid to you by the Plan). Required reimbursements must be satisfied before Plan benefits may continue.

Workers Compensation

This Plan and the Plan coverage provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

ADDITIONAL FUNDING INFORMATION

The Company paid the cost of the LTD income protection coverage.

Dow pays the entire cost of the Plan from its general assets.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for Plan Benefits - Lincoln is both the Initial Claims Reviewer for Claims for Plan Benefits and the Appeals Administrator for denied Claims for Plan Benefits.

ADDITIONAL DEFINITIONS

"Active Employment" means the Employee must be actively at work for the Employer on a full-time or part-time basis and paid regular earnings and perform such work either (1) at the Employer's usual place of business, or (2) at a location to which the Employer's business requires the Employee to travel.

An Employee will be considered actively at work if he was actually at work on the day immediately preceding a weekend (except where one or both of these days are scheduled work days); a holiday (except when the holiday is a scheduled work day); a paid vacation; any non-scheduled work day; an excused leave of absence (except medical leave for the Covered Person's

own disabling condition, voluntary leave of absence in lieu of lay-off and lay-off); and an emergency leave of absence (except emergency medical leave for the Covered Person's own disabling condition).

"Any Occupation" means as follows:

- with respect to Covered Persons whose primary work location is either the Employer's Philadelphia, Knoxville or Houston site, the Covered Person's own job or any Rohm and Haas Company bargained-for job that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity; or
- with respect to Covered Persons whose primary work location is either the Employer's Louisville or Bristol site, any Rohm and Haas Company bargained-for or non-bargained job that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Benefits, Lincoln, and, with respect to reviewing an adverse Claim for an Eligibility Determination, the Global Benefits Director and the Associate Director of North America Benefits for The Dow Chemical Company.

"Appropriate Available Treatment" means care or services which are:

- generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within the Covered Person's geographical region;
- provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
- in accordance with generally accepted medical standards of practice.

"Basic Monthly Earnings" means:

- with respect to Covered Persons whose primary work location is the Employer's Knoxville site, the Covered Person's average base hourly rate during the highest paid 13 weeks out of the last 26 weeks before Disability or Partial Disability.
- with respect to Covered Persons whose primary work location is either the Employer's Philadelphia, Louisville, Bristol, or Houston site, the Covered Person's monthly rate of earnings from the Employer in effect immediately prior to the date Disability or Partial Disability begins. However, such earnings will not include bonuses, commissions, overtime pay and extra compensation.

"Covered Person" means an Employee covered under this Plan.

"Disability" or "Disabled" means as follows:

- except with respect to DRA, as a result of Injury or Sickness, the Covered Person is unable to perform the Material and Substantial Duties of Any Occupation.

- with respect to DRA, as a result of Injury or Sickness, the Covered Person is Totally and Permanently unable to perform the Material and Substantial Duties of Any Occupation.

"Disability Benefits under a Retirement Plan" means money which:

- is payable under a Retirement Plan due to Disability as defined in that plan; and
- does not reduce the amount of money which would have been paid as Retirement Benefits at the normal retirement age under the plan if the Disability had not occurred. (If the payment does cause such a reduction, it will be deemed a Retirement Benefit as defined in this Plan.)

"Eligibility Date" means the date an Employee becomes eligible for coverage under this Plan.

"Eligible Survivor" means the Covered Person's spouse or Domestic Partner, if living, otherwise the Covered Person's children under age 25.

"Eligibility Waiting Period" means the continuous length of time an Employee must be in Active Employment (3 months) to reach their Eligibility Date.

"Elimination Period" means a period of 365 consecutive days of Disability or Partial Disability for which no benefit is payable. If the Covered Person returns to work for any 30 or fewer days during the Elimination Period and cannot continue, the Plan Administrator will count only those days the Covered Person is Disabled or Partially Disabled to satisfy the Elimination Period.

"Employer" means Rohm and Haas Company and its Participating Employers.

"Family and Medical Leave" means a leave of absence for the birth, adoption or foster care of a child, or for the care of the Covered Person's child, spouse or parent or for the Covered Person's own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"Initial Claims Reviewer" means, with respect to deciding Claims for Plan Benefits, Lincoln, and, with respect to deciding a Claim for an Eligibility Determination, the North America Health and Welfare Plans Leader for The Dow Chemical Company.

"Injury" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

- any Disability which begins more than 60 days after an Injury will be considered a Sickness; and
- any Injury which occurs before the Covered Person is covered under this Plan, but which accounts for a medical condition that arises while the Covered Person is covered under this Plan will be treated as a Sickness.

"Last Monthly Benefit" means the Monthly Benefit payable to the Covered Person prior to their death without any reduction for earnings received from employment.

“Lincoln” means Lincoln National Life Insurance Company, 100 Liberty Way, Dover, New Hampshire 03820.

“Material and Substantial Duties” means responsibilities that are normally required to perform the Covered Person’s Own Occupation, or any other occupation, and cannot be reasonably eliminated or modified.

“Monthly Benefit” means the monthly amount payable by the Plan Sponsor to the Disabled or Partially Disabled Covered Person.

“Own Occupation” means the Covered Person’s occupation that he was performing when their Disability or Partial Disability began. For the purposes of determining Disability under this Plan, the Plan will consider the Covered Person’s occupation as it is normally performed in the national economy.

“Partial Disability” or “Partially Disabled” means the Covered Person, as a result of Injury or Sickness, is able to:

- perform one or more, but not all, of the Material and Substantial Duties of their Own Occupation or Any Occupation on an Active Employment or a part-time basis; or
- perform all of the Material and Substantial Duties of their Own Occupation or Any Occupation on a part-time basis; and
- earn between 20% and 80% of their Basic Monthly Earnings.

“Physician” means a person who:

- is licensed to practice medicine and is practicing within the terms of their license; or
- is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of their license.

Physician does not include a Covered Person, any family member or domestic partner.

“Proof” means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

- a claim form completed and signed (or otherwise formally submitted) by the Covered Person claiming benefits;
- an attending Physician’s statement completed and signed (or otherwise formally submitted) by the Covered Person’s attending Physician; and
- the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a form or format satisfactory to the Plan Administrator and Lincoln.

"Regular Attendance" means the Covered Person's personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat the Covered Person's Disability or Partial Disability.

"Retirement Benefit under a Retirement Plan" means money which:

- is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received); and
- is payable upon:
  - early or normal retirement; or
  - Disability, if the payment does reduce the amount of money which would have been paid under the plan at the normal retirement age.

"Retirement Plan" means a plan, such as the Rohm and Haas Company Retirement Plan, which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, informal salary continuation plan, registered retirement savings plan, stock ownership plan, 401(K) or a non-qualified plan of deferred compensation.

"Sickness" means illness, disease, pregnancy or complications of pregnancy.

"Treatment" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the Covered Person chooses to take them or not, and taking drugs and/or medicines.

25.6 Long Term Disability 6

Former SPD Name:	Rohm and Haas Company Health and Welfare Plan's Disability Program's Long Term Disability Program (applicable to closed population of Non-Bargained Employees Whose Disability Began Before January 1, 2010)
Legal Plan Name:	The Rohm and Haas Company Health and Welfare Plan
Legal Plan Number:	Plan 551
Claims Administrators for Claims for Plan Benefits:	Lincoln Group Benefits Disability Claims Lincoln National Life Insurance Company P.O. Box 7211 London, KY 40742-7211

ADDITIONAL ELIGIBILITY INFORMATION

If your Disability began on or after January 1, 2010, you are not eligible for the Plan, but you may contact the Dow Retiree Service Center to see whether you qualify under The Dow Chemical Company Long Term Disability Plan.

Eligible Employees

The Plan applies only to eligible non-bargained Employees of Rohm and Haas Company or a Participating Employer whose qualifying Disability or Partial Disability occurred before January 1, 2010. You are eligible for coverage under the Plan if:

- You were a non-bargained Employee of Rohm and Haas Company or a Participating Employer whose regular work schedule was greater than 20 hours per week;
- You were in Active Employment before January 1, 2010; and
- Your Disability began before January 1, 2010.

Please note that Morton International, Inc. ceased to be a Participating Employer effective October 1, 2009. Please also note that the term "Associated Company" (as defined in the contract with Lincoln, the Plan's claims administrator) is intended to have the same meaning as "Participating Employer" (as defined in the Plan Document).

The definition of "Employee" does not include temporary employees (regardless of whether you are eligible for any other benefit), seasonal employees, leased employees, independent contractors, any person designated by Rohm and Haas Company or a Participating Employer at the time of hire as not eligible to participate in the Plan, even if such ineligible person is

subsequently determined to be an "employee" by any government or judicial authority, or any member of a group or class not eligible for benefits as designated by the Employer.

Enrollment and Cost of Coverage

You did not need to enroll in the Plan; eligible Employees were automatically enrolled, and the Company paid the cost of the LTD income protection coverage.

Family and Medical Leave

If you were a Covered Person and your qualifying Disability occurred prior to January 1, 2010, you were permitted to continue coverage under this Plan if you were on an approved family or medical leave of absence for up to 12 weeks following the date coverage would have otherwise terminated, subject to the following:

- The authorized leave must have been in writing.
- The Covered Person's benefit level, or the amount of earnings upon which the Covered Person's benefit may be based, is that in effect on the date before such leave began.
- Continuation of coverage ceases immediately at the earliest of the following dates: (1) the Covered Person returns to work; (2) the Plan terminates; (3) the Covered Person's job is eliminated; (4) the Covered Person's employment terminates.

COVERAGE DETAIL

Requirements to Receive LTD Payments

To receive LTD payments, none of the exclusions listed in this SPD, below, may apply and you must:

- Meet the eligibility requirements (see Eligibility and Participation);
- Have been Disabled before January 1, 2010 (see Definitions); and
- Have completed the Elimination Period (see Definitions).

Amount of LTD Benefits

The amount of your LTD benefit is equal to 66.7% of your Basic Monthly Earnings (subject to a maximum benefit of $20,000 per month), and then reduced by Other Income Benefits and Other Income Earnings as described below.

<u>Prorated Benefits</u>

For any period for which a Plan benefit is payable that does not extend through a full month, the benefit is paid on a prorated basis. The rate will be 1/30th for each day for such period of Disability.

LTD Benefits Reduced by Other Income Benefits and Other Income Earnings

Your LTD benefit is reduced by Other Income Benefits and Other Income Earnings.

Other Income Benefits means:

1. The amount for which the Covered Person is eligible under:
    - Workers' or Workmen's Compensation Laws;
    - Occupational Disease Law;
    - Title 46, United States Code Section 688 (The Jones Act);
    - any work loss provision in mandatory "No-Fault" auto coverage;
    - Railroad Retirement Act;
    - any governmental compulsory benefit act or law; or
    - any other act or law of like intent.
2. The amount of any Disability benefits which the Covered Person is eligible to receive under:
    - any group short term disability or other long term disability plan of the Plan Sponsor;
    - any governmental retirement system as a result of their employment with the Employer; or
    - any individual short term disability or long term disability plan where the premium is or was wholly or partially paid by the Plan Sponsor. However, the Plan will only reduce the Monthly Benefit if the Covered Person's Monthly Benefit under this Plan, plus any benefits that the Covered Person is eligible to receive under such individual coverage plan exceed 100% of the Covered Person's Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, the Covered Person's Monthly Benefit under this plan is reduced by such excess amount.
3. The amount of Disability Benefits the Covered Person receives under a Retirement Plan, such as the Rohm and Haas Company Retirement Plan.
4. The amount of Disability and/or Retirement Benefits the Covered Person receives or is eligible to receive under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.
5. Any amount the Covered Person receives from any unemployment benefits.

Other Income Earnings means:

1. Any amount the Covered Person receives from any formal or informal sick leave or salary continuation plan(s) or payroll practice; and

2. The amount of earnings the Covered Person earns or receives from any form of employment including severance.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Plan pays a benefit. The sum of Other Income Benefits and Other Income Earnings are deducted from benefits payable under the Plan. The Plan reduces the Covered Person's Disability or Partial Disability benefits by the amount of Other Income Benefits that the Plan estimates are payable to the Covered Person and their dependents. However, the Covered Person's Disability benefit is not be reduced by the estimated amount of Other Income Benefits if the Covered Person:

- provides satisfactory proof of application for Other Income Benefits;
- signs a reimbursement agreement under which, in part, the Covered Person agrees to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;
- if applicable, provides satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and
- if applicable, submits satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

The Plan will not estimate or reduce for any benefits under the Plan Sponsor's pension or retirement benefit plan, until the Covered Person actually receives them.

In the event that the Plan overestimates the amount payable to the Covered Person from any plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse the Covered Person for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgment) or denied (after appeal through the highest administrative level).

The Plan Administrator may help a Covered Person in applying for Social Security Disability Income Benefits. In order to be eligible for assistance the Covered Person must be receiving a Monthly Benefit from the Plan. Such assistance will be provided only if the Plan determines that assistance would be beneficial to the Plan.

Lump Sum Payments

Your LTD Plan benefit also is reduced by Other Income Benefits from a compromise, settlement, award or judgment which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:

- loss of past or future wages;
- impaired earnings capacity;
- lessened ability to compete in the open labor market;

- any degree of permanent impairment; and
- any degree of loss of bodily function or capacity.

For lump sum payments, your LTD benefit reduction is prorated on a monthly basis as follows:

- Over the period of time such benefits would have been paid if not in a lump sum; or
- If such period of time cannot be determined, the lesser of (1) the remainder of the Maximum Benefit Period, or (2) 5 years.

Cost of Living Freeze

After the first deduction for each of the Other Income Benefits, the Monthly Benefit is not further reduced due to any cost of living increases payable under the Other Income Benefits and Other Income Earnings provision of this Plan. This provision does not apply to increases received from any form of employment.

Maximum Benefit Period

A Covered Person's LTD payments may not exceed the maximum benefit period described below. The LTD payments may terminate prior to the maximum benefit period if any of the reasons for discontinuance of the LTD benefits described below apply.

AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
LESS THAN AGE 60	To the greater of SSNRA* or age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 AND OVER	12 months

*SSNRA refers to the Social Security Normal Retirement Age, as determined by the 1983 amendment to the Social Security Act and any subsequent amendments thereto, as follows:

YEAR OF BIRTH	SSNRA
BEFORE 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 AND AFTER	67

Proof of Disability and Continuing Proof of Disability

If you filed a claim for disability payments, you must have provided proof that you had a qualifying Disability or Partial Disability as defined under the Plan. This proof must have been provided no later than 30 days after the end of the 180-day Elimination Period, at your own expense.

Once you are being paid monthly LTD Plan benefits, the Claims Administrator has the right to request proof of a qualifying disability as often as it reasonably chooses. In general, you must provide proof, at your own expense, of the qualifying disability within 30 days of the Claims Administrator's request for such proof.

LTD Plan benefits are not payable if you failed to provide satisfactory proof of a qualifying disability when you filed an LTD claim, or later when the Claims Administrator asks for it; nor are Plan benefits payable for any period of time during which you are not under the care of a Physician for the disability.

A statement from a Physician without objective evidence may not be sufficient proof of a qualifying disability. It is strongly recommended that you work with your doctor to make sure that the Claims Administrator is presented with all available and relevant evidence (e.g., medical examination, tests) to support your claim that you meet the definition of a qualifying disability. For example, a current medical examination and tests should be obtained near in time to the date

you file your claim to show the current status of your disability. Medical examinations and tests by your treating physician are not paid for by the Plan. If the Claims Administrator informs you that you do not have sufficient proof of disability, you should discuss the situation with your physician as soon as possible to make sure that the Claims Administrator is provided all the information that it needs to make a decision on your claim.

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

In determining whether the Covered Person is Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Disabled due to Injury or Sickness and requires the Regular Attendance of a Physician, the Plan will pay the Covered Person a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person provides the Claims Administrator proof of:

- Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

For purposes of determining Disability, the Injury or Sickness must occur and Disability must begin while the Employee is covered under the Plan.

Working While Disabled: Partial Disability

If you become Partially Disabled while you are covered under the Plan, you may qualify for partial disability benefits as long as you are able to prove your continued Disability and as long as work that meets your accommodation needs (as determined by a medical professional) is available to you.

Proof of Partial Disability must be given upon the Claims Administrator's request and at the Covered Person's expense. In determining whether the Covered Person is Partially Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers

loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Partially Disabled and has experienced a loss of earnings due to Injury or Sickness and requires the Regular Attendance of a Physician, he may be eligible to receive a Monthly Benefit, subject to any other provisions of the Plan. To be eligible to receive Partial Disability benefits, the Covered Person may be employed in their Own Occupation or another occupation, must satisfy the Elimination Period and must be earning between 20% and 80% of their Basic Monthly Earnings.

A Monthly Benefit will be paid for the period of Partial Disability if the Covered Person gives to the Claims Administrator Proof of continued:

- Partial Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

The Proof must be given upon the Claims Administrator's request and at the Covered Person's expense.

For purposes of determining Partial Disability, the Injury must have occurred and the Partial Disability must have begun while you were covered under the Plan.

Partial Disability Benefit Amount

For the first 12 months, the work incentive benefit will be an amount equal to the Covered Person's Basic Monthly Earnings multiplied by the benefit percentage shown in the Plan specifications, without any reductions from earnings. The work incentive benefit will be reduced only if the Monthly Benefit payable plus any earnings exceed 100% of the Covered Person's Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus the Covered Person's earnings does not exceed 100% of their Basic Monthly Earnings.

Thereafter, the Monthly Benefit will be calculated as follows:

- First, subtract from the Covered Person's Basic Monthly Earnings the Covered Person's earnings received while he is Partially Disabled. (This figure represents the amount of lost earnings.);
- Second, multiply the amount of lost earnings by 75%; and
- Third, deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from the amount calculated in the second step.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to the Plan, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

Three Month Survivor Benefit

The Plan will pay a lump sum benefit to the Eligible Survivor when Proof is received that a Covered Person died after their Disability had continued for 180 or more consecutive days and while he was receiving a Monthly Benefit. The lump sum benefit will be an amount equal to three times the Covered Person's Last Monthly Benefit.

If the survivor benefit is payable to the Covered Person's children, payment is made in equal shares to the children, including step-children and legally adopted children. However, if any of said children are minors or incapacitated, payment is made on the children's behalf to the court appointed guardian of the property. This payment is valid and effective against all claims by others representing or claiming to represent the children.

If there is no Eligible Survivor, the benefit is payable to the estate.

If an overpayment is due to the Plan at the time of a Covered Person's death, the benefit payable under this provision is applied toward satisfying the overpayment.

Discontinuation of the Long Term Disability Benefit

The Monthly Benefit ceases on the earliest of the date on which the Covered Person:

1. Fails to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;
2. Fails to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
3. Refuses to be examined or evaluated at reasonable intervals;
4. Refuses to receive Appropriate Available Treatment;
5. Refuses a job with the Employer where workplace modifications or accommodations were made to allow the Covered Person to perform the Material and Substantial Duties of the job;
6. Is able to work in their Own Occupation on a part-time basis, but chooses not to;
7. Has current Partial Disability earnings that exceed 80% of their Basic Monthly Earnings. (For these purposes, the Plan averages earnings over three consecutive months rather than immediately terminating their benefit once 80% of Basic Monthly Earnings has been exceeded.);
8. Is no longer Disabled or Partially Disabled according to this Plan;
9. Reaches the end of the Maximum Benefit Period;
10. Dies;
11. Retires; or

12. Quits employment.

To Whom LTD Payments are Paid

In general, the Plan benefit is payable only to the Covered Person. However, if a benefit is payable to a Covered Person's estate or to a Covered Person who is not competent, the Plan has the right to pay up to $2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Termination of a Covered Person's Coverage

A Covered Person ceases to be covered under the Plan on the earliest of the following dates:

- the date the Plan terminates, but without prejudice to any claim originating prior to the time of termination;
- the date the Covered Person is no longer an Employee of Rohm and Haas Company or of a Participating Employer;
- the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the coverage will be continued for an Employee absent due to Disability during the Elimination Period; or
- the date the Covered Person ceases active work due to a labor dispute, including any strike, work slowdown, or lockout.

LIMITATIONS AND EXCLUSIONS

What LTD Does Not Cover

LTD benefits under the Plan are not paid unless you were a Covered Person, satisfied the Elimination Period requirement, met the definition of Disability or Partial Disability before January 1, 2010, and are under the care of a Physician. No benefits are paid during periods of incarceration or imprisonment. In addition, no benefits are payable from the Plan for Disabilities or Partial Disabilities due to:

- Any war (declared or undeclared) or act of war;
- Intentionally inflicted injuries while sane or insane;
- Active participation in a riot;
- A pre-existing condition (see Pre-Existing Condition Exclusion, below);
- Your committing, or attempt to commit, a felony or misdemeanor; or
- Cosmetic surgery, unless in connection with an injury or illness sustained while covered under the LTD Plan.

Pre-Existing Condition Exclusion

The Plan does not cover any Disability or Partial Disability which:

- is caused or contributed to by, or results from, a Pre-Existing Condition; and
- begins in the first 12 months immediately after the Covered Person's effective date of coverage.

Pre-Existing Condition means a condition resulting from an Injury or Sickness for which the Covered Person is diagnosed or received Treatment within three months prior to the Covered Person's effective date of coverage.

Mental Illness and/or Substance Abuse Limitation

The benefit for disability due to Mental Illness and/or Substance Abuse will not exceed a combined period of 24 months of monthly benefit payments while you are covered under the Plan; however, if you are in a Hospital or Institution for Mental Illness and/or Substance Abuse at the end of the combined period of 24 months, the monthly benefit will continue to be paid during the period of your confinement.

If you are not confined in a Hospital or Institution for Mental Illness and/or Substance Abuse, but are fully participating in an extended treatment plan for the condition that caused your Disability, the monthly benefit will be payable to you for up to a combined period of 36 months.

ANCILLARY BENEFITS

If you are receiving benefit payments under the Plan, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits are not provided under the Plan. Instead, the terms of the ancillary benefit plans may extend eligibility to you because of your status under the Plan.

The following information is provided here only for your convenience. If there is any inconsistency between this information and the information in the summary plan description and other legal documents for the applicable ancillary benefit plan, the summary plan description and other legal documents for the applicable ancillary benefit plan will govern.

BENEFIT COVERAGE	WHAT HAPPENS TO COVERAGE WHILE ON AN APPROVED DISABILITY
EMPLOYEE PURCHASED LIFE INSURANCE	You are eligible for coverage while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work, and you must make timely premium contributions in order to continue coverage.
REIMBURSEMENT ACCOUNTS (HEALTH CARE FLEXIBLE SPENDING ACCOUNT	You may not continue to make contributions to DCFSA or HCFSA while you are receiving LTD payments.

(HCFSA) AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA))	
MEDICAL AND DENTAL INSURANCE	In general, you are eligible to continue coverage for yourself and your eligible dependents under The Dow Chemical Company Medical Care Program, The Dow Chemical Company Dental Assistance Program and/or The Dow Chemical Company Insured Health Program, while you are receiving Plan benefit payments, as long as you continue to make any required contributions. Refer to the summary plan descriptions for those programs for more information. You may qualify for Social Security disability benefits, or you may be eligible for Medicare. Ask your local Social Security office for details.
MEDICARE	If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (FORMERLY PAI)	You are eligible for accidental, death and dismemberment insurance while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work and you must make timely premium contributions.
COMPANY-PAID LIFE INSURANCE	You are eligible for company-paid life insurance coverage while you are receiving Plan benefit payments.
SERVICE CREDIT	You do not continue to accumulate benefit service while you are receiving Plan benefit payments.

TRAVEL ACCIDENT INSURANCE AND OCCUPATIONAL ACCIDENT INSURANCE	Travel accident and occupational accident insurance coverage (such as through Dow's BTA/OAI Plan) stops when you begin receiving Plan benefit payments.
VACATION TIME	Vacation time cannot be taken while you are receiving Plan benefit payments. Your vacation accruals will remain the same as during your pre-disability period through the end of the calendar year in which your partial disability status commenced. Beginning January 1 of the subsequent calendar year, your vacation accrual will be based on your working hours in that year (assuming you remain in partial disability status).
HOLIDAYS	A Holiday is considered a regular work day when calculating disability benefits.
401(K) PLAN	In general, you may leave your account in the 401(k) plan until April 1st after you reach age 701/2. If you have a loan(s), you must continue to repay the loan. If no loan payments are made and you do not return to work within one year, your loan defaults.
PENSION PLAN	In general, you continue to earn service credit under the Rohm and Haas Company Retirement Plan while you are receiving Plan benefit payments.

SUBROGATION

As used in this Appendix these terms have the following meaning:

- "Covered Person" means a participant in the Plan, the parents and legal guardians of a participant who is a minor, and the heirs, administrators, and executors of a participant's estate.
- "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition, without regard to whether such party caused the illness, injury, or condition. The term "Responsible Party" includes the liability insurer of such party, any Insurance Coverage, and any employer, agent, or principal of such party.
- "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

The Plan’s Entitlement to Reimbursement

Subrogation. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to the Covered Person’s injury, illness or condition to the full extent of benefit provided or to be provided by the Plan.

Reimbursement. If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition (including attorneys’ fees and other costs incurred in enforcing the Plan’s rights), up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits from the Plan, the Covered Person agrees that if they receive any payment from any Responsible Party as a result of an injury, illness or condition, they will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person’s fiduciary duty to the Plan, and the Plan may pursue equitable remedies to recover the monies or withhold future benefits until reimbursement is made.

Lien Rights. The Plan will automatically have a lien to the extent of benefits paid by the Plan for which the Responsible Party is alleged to be liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person’s representative or agent; the Responsible Party, the Responsible Party’s insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim. By accepting benefits from the Plan, the Covered Person acknowledges that the Plan’s recovery rights are a first priority claim against all Third Parties and are to be paid to the Plan before any other claim for the Covered Person’s damages (including before attorneys’ fees and other expenses). The Plan is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make them whole (i.e., the “make whole” doctrine will not apply).

Applicability to All Settlements and Judgments. The Plan is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-

economic damages and/or general damages only (i.e., the “common fund” doctrine will not apply).

Plan Not Required to Pay Court Costs or Attorneys’ Fees. The Plan is not required to participate in or pay court costs or attorneys’ fees to any attorney hired by the Covered Person to pursue the Covered Person’s damage claim. Should it be necessary for the Plan to institute legal action against a Covered Person (or assignee) for failure to reimburse the Plan in full, or for failure to honor the Plan’s equitable interest in the amount recovered from a Responsible Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys’ fees.

Your Responsibilities

The Covered Person is required to fully cooperate with the Plan’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person’s intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and their agent shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. The rights described in this Section are assigned to the Plan without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Plan an assignment and other instruments that may be used to facilitate securing the rights of the Plan. The Covered Person shall do nothing to prejudice the Plan’s subrogation or recovery interest or to prejudice the Plan’s ability to enforce the terms of the Plan’s provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Plan may withhold future benefits or terminate the Participant and the Covered Person from the Plan if the Covered Person does not fully cooperate with the Plan’s efforts to recover the benefits paid by the Plan. In addition, if the Participant or the Covered Person is terminated from eligibility under any benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of failure to reimburse that benefit plan, the Plan Administrator may determine that the Participant and/or the Covered Person are disqualified from eligibility for coverage under the Plan.

The Covered Person acknowledges by accepting benefits from the Plan that the Plan has the right to conduct an investigation regarding the injury, illness or condition in order to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and their agent of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Covered Person’s obligation to reimburse the Plan is limited to the amount of benefits the Plan has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. However, if the Plan must institute a legal action because a Covered Person fails to reimburse the Plan in full or to honor the Plan’s equitable interest in any recovery, the Covered person will be liable for all costs of collection, including reasonable attorneys’ fees.

If the Plan has overpaid you any overpayments made to you may be offset by the Plan in future payments or claims.

Jurisdiction

For purposes of this Section, by accepting benefits from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of their present or future domicile.

Overpayments

Whenever a disability payment is made under the Plan, the Claims Administrator has the right to recover any overpayments (including Survivor Benefits), whether due to fraud, an error in processing a claim, or your receipt of other sources of income. You will be required to reimburse the Claims Administrator for the full amount of the overpayment. The method by which the repayment is made will be determined by the Claims Administrator (this repayment will never exceed the benefit amount paid to you by the Plan). Required reimbursements must be satisfied before Plan benefits may continue.

Workers Compensation

This Plan and the Plan coverage provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

ADDITIONAL FUNDING INFORMATION

You did not need to enroll in the Plan; eligible Employees were automatically enrolled, and the Company paid the cost of the LTD income protection coverage. Dow pays the entire cost of the Plan from its general assets.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for Plan Benefits - Lincoln is both the Initial Claims Reviewer for Claims for Plan Benefits and the Appeals Administrator for denied Claims for Plan Benefits.

Time Limitation for Filing a Claim and Filing Proof of Claim

Claims for Plan Benefits - In general, you must have filed a Claim for Plan Benefits within 30 days after the date your qualifying disability begins, and you must have filed your proof of the Disability within 30 days of the request for such proof; otherwise your Claim for Plan Benefits will be denied (unless there are extenuating circumstances as determined by the Claims Administrator).

Claims for Eligibility Determinations - You must have filed a Claim for an Eligibility Determination no later than 30 days after your last day on the payroll of Dow.

Proof of Disability

If you are being paid monthly LTD benefits, the Claims Administrator has the right to request proof of Disability or Partial Disability as often as it reasonably chooses. Monthly Benefits will not be paid with respect to your Disability or Partial Disability if you fail to provide proof that is satisfactory to Lincoln when you file an LTD claim, or later when Lincoln asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Disability.

Claims for Plan Benefits

To submit a Claim for Plan benefits, you must complete a claim form and provide documentation showing that you were Totally Disabled during and for the time required under the Plan. Contact the HR Service Center at:

North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Plan Administrator for Rohm and Haas Long Term Disability Program

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

Group Benefits Disability Claims
Lincoln National Life Insurance Company
P.O. Box 7211
London, KY 40742-7211

Initial Determination

When you submit a Claim for disability benefits to Lincoln, 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 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 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 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 Initial Claims Reviewer's sole discretion, 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 will decide the claim without the additional information.

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

- The specific reason or reasons for denial of the claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary;
- 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;
- 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;
- An explanation of the Plan's appeal procedures and the applicable time limits; and
- 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 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 the Initial Claims Reviewer's notice of denial, assuming that there are not extenuating circumstances, as determined by the Appeals Administrator, 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
- Explanation of the reason why you are appealing the Initial Determination Send your appeal to:

Group Benefits Disability Claims|
Lincoln National Life Insurance Company
P.O. Box 7211
London, KY 40742-7211
Attention: Claims Administrator for Rohm and Haas Long Term Disability Program (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 Appeals Administrator provide you copies of documents, records and other information that is relevant to your Claim, as determined by the Appeals Administrator under applicable federal regulations. 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 take into account all comments, documents, records, etc. submitted to the Appeals Administrator that is related to the Claim without regard to whether such information was submitted or considered in the initial determination. The Appeals Administrator will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator 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 may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

The Appeals Administrator 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 may have up to an additional 45 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 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 Appeals Administrator's sole discretion, 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 will decide the Claim

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

- The specific reason(s) why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement 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;
- If an adverse decision is based on advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;

- 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;
- 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;
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- A statement of your right to bring a civil action under section 502(a) of ERISA.

ADDITIONAL DEFINITIONS

"Active Employment" means the Employee must be actively at work for the Employer on a full-time or part-time basis and paid regular earnings and perform such work either (1) at the Employer's usual place of business, or (2) at a location to which the Employer's business requires the Employee to travel.

An Employee will be considered actively at work if he was actually at work on the day immediately preceding a weekend (except where one or both of these days are scheduled work days); a holiday (except when the holiday is a scheduled work day); a paid vacation; any non-scheduled work day; an excused leave of absence (except medical leave for the Covered Person's own disabling condition, voluntary leave of absence in lieu of lay-off and lay-off); and an emergency leave of absence (except emergency medical leave for the Covered Person's own disabling condition).

"Any Occupation" means any occupation that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

"Appeals Administrator" means, with respect to reviewing an adverse Claim for Benefits, Lincoln, and, with respect to reviewing an adverse Claim for an Eligibility Determination, the Global Benefits Director and the Associate Director of North America Benefits for The Dow Chemical Company.

"Appropriate Available Treatment" means care or services which are:

- generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within the Covered Person's geographical region;
- provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
- in accordance with generally accepted medical standards of practice.

"Basic Monthly Earnings" means the Covered Person's monthly rate of earnings from the Employer in effect immediately prior to the date Disability or Partial Disability begins, up to a maximum of $29,985 per month. Such earnings will not include bonuses, commissions, overtime pay and extra compensation.

"Covered Person" means an Employee covered under this Plan. "Disability" or "Disabled" means as follows:

- For persons other than pilots, co-pilots, and crewmembers of an aircraft, "Disability" or "Disabled" means:
    - during the Elimination Period and the next 24 months of Disability the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of their Own Occupation; and
    - Thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.
    - With respect to Covered Persons employed as pilots, co-pilots and crewmembers of an aircraft, "Disability" or "Disabled" means as a result of Injury or Sickness the Covered Person is unable to perform the Material and Substantial Duties of Any Occupation.

"Disability Benefits under a Retirement Plan" means money which:

- is payable under a Retirement Plan due to Disability as defined in that plan; and
- does not reduce the amount of money which would have been paid as Retirement Benefits at the normal retirement age under the plan if the Disability had not occurred. (If the payment does cause such a reduction, it will be deemed a Retirement Benefit as defined in this Plan.)

"Eligibility Date" means the date an Employee becomes eligible for coverage under this Plan.

"Eligible Survivor" means the Covered Person's spouse or Domestic Partner, if living, otherwise the Covered Person's children under age 25.

"Elimination Period" means a period of consecutive days of Disability or Partial Disability for which no benefit is payable. The Elimination Period is the greater of either (1) the period the Covered Person receives Short Term Disability benefits, salary continuation, or pay from a payroll practice, or any combination thereof, or (2) 180 days.

If the Covered Person returns to work for any 30 or fewer days during the Elimination Period and cannot continue, the Plan Administrator will count only those days the Covered Person is Disabled or Partially Disabled to satisfy the Elimination Period.

"Employer" means Rohm and Haas Company and its Participating Employers. Please note that Morton International, Inc. ceased to be a Participating Employer effective October 1, 2009.

“Extended Treatment Plan” means continued care that is consistent with the American Psychiatric Association’s standard principles of Treatment, and is in lieu of confinement in a Hospital or Institution. It must be approved in writing by a Physician.

“Family and Medical Leave” means a leave of absence for the birth, adoption or foster care of a child, or for the care of the Covered Person’s child, spouse or parent or for the Covered Person’s own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

“Hospital” or “Institution” means a facility licensed to provide Treatment for the condition causing the Covered Person's Disability.

“Initial Claims Reviewer” means, with respect to deciding Claims for Plan Benefits, Lincoln, and, with respect to deciding a Claim for an Eligibility Determination, the North America Health and Welfare Plans Leader for The Dow Chemical Company.

“Injury” means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

- any Disability which begins more than 60 days after an Injury will be considered a Sickness; and
- any Injury which occurs before the Covered Person is covered under this Plan, but which accounts for a medical condition that arises while the Covered Person is covered under this Plan will be treated as a Sickness.

“Last Monthly Benefit” means the Monthly Benefit payable to the Covered Person prior to their death without any reduction for earnings received from employment.

“Lincoln” means Lincoln National Life Insurance Company, 100 Liberty Way, Dover, New Hampshire 03820.

“Material and Substantial Duties” means responsibilities that are normally required to perform the Covered Person’s Own Occupation, or any other occupation, and cannot be reasonably eliminated or modified.

“Mental Illness” means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, the Sponsor will use the replacement chosen or published by the American Psychiatric Association.

“Monthly Benefit” means the monthly amount payable by the Plan Sponsor to the Disabled or Partially Disabled Covered Person.

“Own Occupation” means the Covered Person’s occupation that he was performing when their Disability or Partial Disability began. For the purposes of determining Disability under this Plan, the Plan will consider the Covered Person’s occupation as it is normally performed in the national economy.

"Partial Disability" or "Partially Disabled" means the Covered Person, as a result of Injury or Sickness, is able to:

- perform one or more, but not all, of the Material and Substantial Duties of their Own Occupation or Any Occupation on an Active Employment or a part-time basis; or
- perform all of the Material and Substantial Duties of their Own Occupation or Any Occupation on a part-time basis; and
- earn between 20% and 80% of their Basic Monthly Earnings.

"Physician" means a person who:

- is licensed to practice medicine and is practicing within the terms of their license; or
- is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of their license.

Physician does not include a Covered Person, any family member or domestic partner.

"Proof" means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

- a claim form completed and signed (or otherwise formally submitted) by the Covered Person claiming benefits;
- an attending Physician's statement completed and signed (or otherwise formally submitted) by the Covered Person's attending Physician; and
- the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a form or format satisfactory to the Plan Administrator and Lincoln.

"Regular Attendance" means the Covered Person's personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat the Covered Person's Disability or Partial Disability.

"Retirement Benefit under a Retirement Plan" means money which:

- is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received); and
- is payable upon:
    - early or normal retirement; or

- o Disability, if the payment does reduce the amount of money which would have been paid under the plan at the normal retirement age.

"Retirement Plan" means a plan, such as the Rohm and Haas Company Retirement Plan, which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, informal salary continuation plan, registered retirement savings plan, stock ownership plan, 401(K) or a non-qualified plan of deferred compensation.

"Sickness" means illness, disease, pregnancy or complications of pregnancy.

"Substance Abuse" means alcohol and/or drug abuse, addiction, or dependency.

"Treatment" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the Covered Person chooses to take them or not, and taking drugs and/or medicines.

25.7 Long Term Disability 7

Former SPD Name:	Union Carbide Corporation, a subsidiary of The Dow Chemical Company Long Term Disability Plan
Legal Plan Name:	Union Carbide Corporation Long Term Disability Plan
Legal Plan Number:	Plan 545
Claims Administrators for Claims for Plan Benefits:	MetLife Disability P.O. Box 14590 Lexington, KY 40511-4590 Attention: Union Carbide Corporation Long Term Disability Plan

ADDITIONAL ELIGIBILITY INFORMATION

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.

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 Section 18.

ADDITIONAL ENROLLMENT INFORMATION

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.

COVERAGE DETAIL

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

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.

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.

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.

RECEIVING BENEFIT PAYMENTS

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

ADDITIONAL TAX CONSEQUENCES INFORMATION

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.

LIMITATIONS AND EXCLUSIONS

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.

INTERACTION WITH OTHER BENEFITS

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 the Claims Procedures of this section.

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.

Medicare

If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).

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.

ADDITIONAL FUNDING INFORMATION

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

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.

FILING A CLAIM FOR A PLAN BENEFIT

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

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.

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.

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, 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.

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.

ADDITIONAL DEFINITIONS

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 Section 18.

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.

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.

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 Section 18.

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.

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).

Section 26. Appendix D - Business Travel Accident, Occupational Accident, and Travel Accident Information

26.1 Business Travel Accident, Occupational Accident and Travel Accident

Former SPD Name:	The Dow Chemical Company Business Travel Accident and Occupational Accident Insurance Plan
Legal Plan Name:	Business Travel Accident And Occupational Accident Insurance Plan
Legal Plan Number:	Plan 502
Claims Administrators for Claims for Plan Benefits:	National Union Fire Insurance Company of Pittsburgh PA (NUFIC), an AIG company. NUFIC Accident and Health Claims Division P. O. Box 25987 Shawnee Mission, KS 66225-5987 1-800-551-0824

ADDITIONAL FUNDING INFORMATION

Dow pays the entire premium for Plan coverage under the Plan. Benefits under the Plan are insured through a group insurance contract with National Union Fire Insurance Company of Pittsburgh PA (NUFIC). Benefits, if any, that are not paid through a group insurance contract are paid from the Company's or Participating Employer's general assets.

Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from assets of the Plan, if any.

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

ADDITIONAL ELIGIBILITY INFORMATION

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

ADDITIONAL ENROLLMENT INFORMATION

Enrollment is automatic.

EMPLOYEE CONTRIBUTION

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

COVERAGE DETAIL

Benefits are paid when loss of life, Total and Permanent Disability, or serious injury as listed in the table below, occur as the result of a covered accidental injury and within 365 days of such injury. Benefits are paid in U.S. dollars. If a benefit cannot be paid in U.S. dollars due to local laws, the benefit will be paid by the Participating Employer in local currency so as to comply with applicable law. Such payment will be converted to local currency using the exchange rate in effect at the payor bank designated by the Participating Employer on the date the payment is issued to the beneficiary. By a separate agreement between the Plan Sponsor and the insurance carrier, the Participating Employer will then be reimbursed by the insurance company. The U.S. dollar amount is based on the percentage of Principal Sum payable and, if applicable, your Annual Base Salary, determined as of the date of the covered accident. The Principal Sum is the amount determined in this section. The percentage of the Principal Sum is determined in accordance with the Table of Losses. If you are paid in a currency other than U.S. dollars, your Annual Base Salary will be converted to U.S. dollars using the currency exchange rate in effect as of the date of the covered accident. If you are on an expatriate assignment, the U.S. dollar amount is based on the percentage of Principal Sum payable, and, if applicable, the Annual Base Salary in home-country currency and the currency exchange rate, determined as of the date of the covered accident. The home-country Annual Base Salary is determined by using the comparable job level and pay position in the relevant home-country salary structure.

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

Table of Losses

	PERCENTAGE OF PRINCIPAL SUM
LOSS OF:	
LIFE	**100%**
BOTH HANDS OR BOTH FEET	**100%**
TOTAL SIGHT OF BOTH EYES	**100%**
ONE HAND AND ONE FOOT	**100%**
ONE HAND AND THE TOTAL SIGHT OF ONE EYE	**100%**
ONE FOOT AND THE TOTAL SIGHT OF ONE EYE	**100%**
SPEECH AND HEARING IN BOTH EARS	**100%**
ONE HAND OR ONE FOOT	**50%**
TOTAL SIGHT OF ONE EYE	**50%**
SPEECH OR HEARING IN BOTH EARS	**50%**
HEARING IN ONE EAR	**25%**
THUMB AND INDEX FINGER OF THE SAME HAND	**25%**
PARALYSIS:	
QUADRIPLEGIA	**100%**
PARAPLEGIA	**50%**
HEMIPLEGIA	**50%**
UNIPLEGIA	**25%**
COMA	**1% per month for 100 months or until the coma ends**
SEVERE BURN:	
FACE AND NECK AND HEAD	**99%**

HAND AND FOREARM BELOW ELBOW JOINT	**22.5%**
UPPER ARM BELOW SHOULDER JOINT TO ELBOW JOINT	**13.5%**
TORSO BELOW NECK TO SHOULDER JOINTS AND HIP JOINTS	**36%**
THIGH BELOW HIP JOINT TO KNEE JOINT	**9%**
FOOT AND LOWER LEG BELOW KNEE JOINT	**27%**
PERMANENT TOTAL DISABILITY	**100%**

Coma

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

Exposure

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

Disappearance

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

Multiple Losses

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

Paralysis

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

Permanent Total Disability

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

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

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

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

Rehabilitation Benefit.

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

Seat Belt and Air Bag Benefits

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

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

Carjacking

If you suffer one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Coma Benefit, or Paralysis benefit provided by the Policy as a result of a carjacking of an automobile (as defined in the Policy) you are

operating, or riding as a passenger in, (including getting in or out of) such automobile, you will be eligible for an additional benefit equal to the lesser of: (1) $10,000; or (2) 10% of the largest benefit payable under any one of the benefits specified above due to the carjacking. Only one benefit is payable under as a result of the same carjacking.

Verification of the carjacking must be a part of an official report of the carjacking or be certified, in writing, by the investigating officer(s).

Psychological Therapy

You may be eligible under the Policy for certain psychological therapy expenses that are due to your injury that caused a covered dismemberment under the Policy. The psychological therapy expenses must be incurred within one year after the date of the accident causing the Injury. The amount payable for this benefit is the lesser of $10,000 or 10% of your principal sum. Covered psychological therapy expenses do not include any expenses for or resulting from an injury covered by workers' compensation or other similar law. For more information on covered psychological therapy expenses and the scope of this benefit, please refer to the Policy.

Severe Burns

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

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

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

War Risk

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

your travel there in order to be covered under the Plan for losses caused by or resulting from declared or undeclared war occurring in one of these countries.

Weekly Accident Indemnity

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

Repatriation of Remains

If you, or for the BTA component, your Spouse or Domestic Partner, or Dependent Child die due to an accidental injury covered by this Plan or an emergency sickness (as defined in the Policy) and the accidental injury or emergency sickness occurs while outside a 100 mile (161 km) radius of your current primary residence, the Plan will pay for covered expenses reasonably incurred to return the decedent's body to the current place of primary residence, up to a maximum of $1,000,000. Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffin or receptacle adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

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

Home Alteration and Vehicle Modification Benefit

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

LIMITATIONS AND EXCLUSIONS

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

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

BENEFICIARIES

Employees Covered by a Company-Provided Life Insurance Policy.

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

Employees with No Company-Provided Life Insurance.

If you are not covered by a "life insurance policy" for which Dow pays the premium, and you do not have a designated beneficiary on file for BTA/OAI, your beneficiaries are (1) your Spouse/Domestic Partner, (2) if you have no surviving Spouse/Domestic Partner, your Children,

or (3) if you have neither Spouse/Domestic Partner nor the Children surviving, your parents, or (4) if you have no parents surviving, your brothers and sisters or (5) if you have no Spouse/Domestic Partner, children, parents or brothers and sisters surviving, your estate.

ADDITIONAL ASSIGNMENT INFORMATION

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.

PROVISIONS THAT APPLY ONLY TO BUSINESS TRAVEL ACCIDENT

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

Non-Duplication of Benefits

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

Dependent Eligibility

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

Coverage Provisions

Periods of Coverage

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

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

BTA coverage ends on the day you Retire, begin receiving payments for “full disability” or “total disability” under The Dow Chemical Company Long Term Disability Program (applicable to those actively at work on or after January 1, 2008) (the “LTD Plan”), begin a leave of absence,

or terminate employment with a Participating Employer. However, BTA coverage continues while you are receiving partial disability payments under the LTD Plan.

Dependent Coverage

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

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

Principal Sum

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

Multiple Losses

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

Beneficiaries

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

PROVISIONS THAT APPLY ONLY TO OCCUPATIONAL ACCIDENT

Inbound and Outbound Employees are not eligible for the Occupational Accident Insurance benefits in this section.

Non-Duplication of Benefits

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

Dependent Eligibility

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

Coverage Provisions

Periods of Coverage

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

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

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

Principal Sum

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

Benefit Limits

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

PROVISIONS THAT APPLY ONLY TO TRAVEL ACCIDENT

This Section applies only to Inbound and Outbound Employees.

Dependent Eligibility

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

Coverage Provisions

Periods of Coverage

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

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

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

Principal Sum

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

Multiple Losses

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

FILING A CLAIM FOR A PLAN BENEFIT

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

Deadline to File a Claim and File Proof of Claim

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

Claims for an Eligibility Determination - A Claim for an Eligibility Determination must be filed before the end of the year in which you seek enrollment or for which you claim you were

charged an incorrect premium. Failure to file a Claim within the deadline will result in denial of the Claim.

Claim for Plan Benefits

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

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

Notification of Accident

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

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

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

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

Proof of Loss

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

How to File Accidental Death Claims

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

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

Send the completed claim to:

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

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

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

How to File Severe Burn and Accidental Dismemberment/Paralysis Claims

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

- Annual Base Salary in home-country currency of the Employee on the date of the accident
- Job Description
- Brief written description of the accident, including date, time, and location
- Copy of the police report and, if applicable, internal accident report
- Copy of newspaper or other articles related to the accident
- For BTA claims, an itinerary, appointment calendar or other supporting documents confirming the Insured Person was traveling on Company business when the accident occurred
- For BTA claims, confirmation of approved business travel

Send the completed claim to:

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

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

NUFIC
Accident and Health Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225-5987
Midland, MI 48641-2169 USA
USA 1-800-551-0824

How to File Permanent Total Disability Benefit Claims

In addition to the information requested on the Permanent Total Disability claim form, the following information and documents will be required before submitting a Claim to NUFIC.

Your local HR Solutions contact and BTA/OAI Claims Processor will assist in gathering the Company-related information:

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

Send the completed claim to:

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

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

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

<u>Legal Actions</u>

No action at law or in equity may be brought to recover on this Plan prior to the expiration of the Applicable Limitations Period described in main body of this SPD.

Initial Decision on a Claim for Plan Benefits

NUFIC is the Initial Claims Reviewer for Claims for Plan Benefits and will review your Claim and notify you of its decision to approve or deny your Claim. Claims for Plan Benefits involving a determination of disability will be decided in accordance with this Appendix.

Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims

The Initial Claims Reviewer for Claims for Plan Benefits will review your Claim and notify you of its decision to approve or deny your Claim.

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

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

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

- The specific reason or reasons for the denial of the Claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why such material or information is necessary;
- An explanation of the Plan's appeal procedures and the applicable time limits;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your Claim, without regard to whether the advice was relied upon in denying your Claim; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your Claim to the Initial Claims Reviewer for Claims for Plan Benefits);
- If the denial of your Claim was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical

circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for Plan Benefits, as determined by the Initial Claims Reviewer for Claims for Plan Benefits under applicable federal regulations; and
- A statement of your right to bring a civil action under section 502(a) of ERISA, if your Claim is denied upon review.

Appealing a Denial of a Claim for Plan Benefits

NUFIC is the Appeals Administrator for Claims for Plan Benefits and will review your appeal and notify you of its final decision. Claims for Plan Benefits involving a determination of disability will be decided in accordance with this Appendix.

<u>Death, Severe Burn, and Dismemberment/Paralysis Benefit Claims</u>

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

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

Send the appeal to:

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

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

After the Appeals Administrator for Claims for Plan Benefits receives your written request to appeal the initial determination, the Appeals Administrator for Claims for Plan Benefits will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator for Claims for Plan Benefits will look at the Claim anew.

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

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

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

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

Permanent Total Disability Benefit Claims

If the Initial Claims Reviewer for Claims for Plan Benefits has denied your Claim, you may appeal the decision. You must file a written appeal within 180 days of receipt of the notice of denial from the Initial Claims Reviewer for Claims for Plan Benefits, assuming that there are no

extenuating circumstances, as determined by the Appeals Administrator for Claims for Plan Benefits, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

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

Send the appeal to:

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

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

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

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

- If the initial determination was based on medical judgment, the Appeals Administrator for Claims for Plan Benefits will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be the same person consulted in connection with the initial determination, and will not be a subordinate who reports to the person who was consulted in connection with the initial determination.
- The Appeals Administrator for Claims for Plan Benefits will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial decision, without regard to whether the advice was relied upon in making the initial decision.
- In addition, 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.

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

- The specific reason or reasons why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to

your Claim for Plan Benefits, as determined by the Appeals Administrator for Claims for Plan Benefits under applicable federal regulations;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about the voluntary appeal procedures;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits); (ii) the views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your appeal, without regard to whether the advice was relied upon in denying your appeal; and (iii) a disability determination made by the Social Security Administration (if submitted by you as part of your appeal to the Appeals Administrator for Claims for Plan Benefits);
- If the denial of your Claim on appeal was based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the decision, or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and
- A statement of your right to bring a civil action under section 502(a) of ERISA and any deadline for filing a lawsuit, including the calendar date of the deadline to file a lawsuit for your Claim.

ADDITIONAL DEFINITIONS

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

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

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

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

Appeals Administrator means, with respect to reviewing an adverse Claim for Plan Benefits, NUFIC. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the person, group of persons, or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Appeals Administrator for Claims for an Eligibility Determination is listed in Section 18.

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

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

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

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

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

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

- A Dependent Child who is a full-time student at an accredited institution of higher learning on a full-time basis is eligible until their 26th birthday.
- A Dependent Child who is physically or mentally incapable of self-support upon attaining 19 years of age may continue coverage under the Plan until the later of: (i) the date they are no longer incapacitated, or (ii) the Participant is are no longer covered by the Plan. Proof may be required by the Plan of the Dependent Child's physical or mental incapacity. Contact HR Solutions at least 60 days before the Dependent Child's birthday if this applies to you.

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

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

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

soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

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

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

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

Initial Claims Reviewer means, with respect to deciding Claims for Plan Benefits, NUFIC. The Initial Claims Reviewer with respect to deciding Claims for an Eligibility Determination is the person, group of persons or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons, or entity designated as the Initial Claims Reviewer for Claims for an Eligibility Determination is listed in Section 18.

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

Limb means entire arm or entire leg.

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

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

OAI means the Occupational Accident Insurance component of the Plan. Occupational means while on the business of Dow or while On Premise of Dow.

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

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

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

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

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

Principal Sum means the benefit payable based on the applicable loss or injury, as described above. Quadriplegia means complete and irreversible paralysis of both upper and lower limbs.

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

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

- acrobatic or stunt flying
- racing
- any endurance tests
- any flight on a rocket-propelled or rocket-launched aircraft
- fire fighting
- exploration
- pipe line inspection
- power line inspection
- any form of hunting

- bird or fowl herding
- aerial photography
- banner towing
- any test or experimental purpose
- any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

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

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

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

Uniplegia means the complete and irreversible paralysis of one Limb.

Section 27. Appendix E. Legal Services Information

27.1 Legal Services

Former SPD Name:	The Dow Chemical Company Group Legal Plan
Legal Plan Name:	Group Legal Plan
Legal Plan Number:	542
Claims Administrators for Claims for Plan Benefits:	MetLife Legal Plans Client Service Representative Telephone: 800-821-6400

ADDITIONAL ELIGIBILITY INFORMATION

You are eligible to enroll in the Plan if you are an active Employee of a Participating Employer. If you enroll in the Plan, your Spouse, Domestic Partner or Dependent Child are eligible for certain services as described in this section.

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

ADDITIONAL ENROLLMENT INFORMATION

If you are an eligible Employee, you may enroll in the Plan as follows:

- During your Participating Employer's annual enrollment period;
- By submitting a properly completed election form to the person designated on the form within 90 days after your date of hire; or
- If you became an Employee of a Participating Employer as part of the separation of Dow Inc. from DowDuPont Inc., within 31 days from the date you became an Employee of a Participating Employer.

During open enrollment, you may also disenroll from the Plan, or you may change or update your Plan benefits selection. You are permitted to make changes to your enrollment or Plan benefits during the year only for a Qualifying Life Event to the extent provided below.

You may enroll in the Plan during the year only upon one of the following Qualifying Life Events:

- You transition from being a less-than-full-time employee to a full-time employee;
- You return from an approved leave of absence (including military leave);
- You return from an international assignment;
- An event that changes your legal marital status, including Marriage, Domestic Partnership, death of your Spouse/Domestic Partner, divorce, annulment, or Termination of Domestic Partnership;
- An event that increases your number of Dependent Children, including birth, adoption, placement for adoption or death of your Dependent;
- You or your Spouse lose eligibility for pre-paid legal coverage; or
- A termination of employment for your Spouse/Domestic Partner.

You may disenroll from the Plan upon the following Qualifying Life Event: You transition from being a full-time employee to a less-than-full-time employee.

You must submit a written request to enroll or disenroll from the Plan, together with all required proof, within 90 days following the Qualifying Life Event. The following types of proof may be required: birth certificates, passports, marriage certificates, domestic partner signed statements, social security numbers, evidence of loss of spouse/domestic partner or dependent's employment, or any other form of proof the Plan Administrator deems appropriate. As a term and condition of you requesting enrollment for your Spouse, Domestic Partner and Dependent Children under the Program, you are representing to the Plan that (a) your dependents meet the Plan definition for eligible dependents and (b) you will timely submit all documentation requested or required by the Plan to validate your dependent's eligibility. Your dependent's enrollment will not be considered to have been completed until you have submitted all required paperwork. Claims for benefits will be pended until such paperwork has been provided and approved, and to the extent any claims are paid and you subsequently fail to submit such paperwork, you will be required to repay the Plan.

COVERAGE DETAIL

Date of Participation

Generally, your Plan coverage for a Plan Year becomes effective on the following days, as applicable:

- Your hire date if you submit a properly completed enrollment form within 31 days after your hire date;
- Your enrollment request date if you submit a properly completed enrollment form within 32-90 days after your hire date;
- The first day of the Plan Year following the annual enrollment period for enrollment elections you make during that annual enrollment period;

- The Qualifying Life Event date if you submit a properly completed enrollment form within 31 days after the Qualifying Life Event; or
- The enrollment request date if you submit a properly completed enrollment form within 32-90 days after the Qualifying Life Event.

Cessation of Participation

Your participation under the Plan ends on the earliest to occur of the following:

- The date you cease to meet the eligibility and participation requirements under the Plan;
- The last day of the applicable period for which you make the contribution required for Plan participation;
- The effective date of a Plan amendment that terminates your coverage under the Plan; or
- The date of termination of the Plan.

If you cease to be eligible to participate in the Plan or your employment with a Participating Employer ends, the Plan will cover the legal fees for those Covered Services that were opened and pending during the period you were enrolled in the Plan. No new matters may be started after you become ineligible to participate in the Plan.

Covered Services

Participants are entitled to receive the legal services described below, subject to meeting the limitations and conditions described in this Appendix. All Covered Services are available to you, your Spouse and other eligible Dependents, unless otherwise noted.

The personal legal services will be provided through a panel of carefully selected participating law firms. Lawyers in this network of participating law firms are called "Plan Attorneys."

ADVICE AND CONSULTATION

Office Consultation

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out their options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at their own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake their own representation.

Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out their options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at their own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake their own representation.

CONSUMER PROTECTION

Consumer Protection Matters

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

DEBT MATTERS

Debt Collection Defense

This benefit provides Participants with an attorney’s services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or

garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy, any action arising out of family law matters including support and post decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Identity Theft Defense

This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy or Wage Earner Plan

This service covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Employer, even if the Employee or spouse chooses to reaffirm that specific debt.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

DEFENSE OF CIVIL LAWSUITS

Administrative Hearing Representation

This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense

This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment

matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

DOCUMENT PREPARATION

Affidavits

This service covers preparation of any affidavit in which the Participant is the person making the statement

Deeds

This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes

This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Document Review

This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds

involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

FAMILY LAW

Name Change

This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement

This service covers representation of the Employee and includes the negotiation, preparation, review and execution of a Prenuptial Agreement between the Employee and their fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Employee. The fiancé/partner must have separate counsel or must waive their right to representation. It does not include subsequent litigation arising out of a Prenuptial Agreement.

Protection from Domestic Violence

This service covers the Employee only, not the spouse or dependents, as the victim of domestic violence. It provides the Employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Employee and spouse. Legitimization of a child for the Employee and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested or Uncontested)

This service covers establishing a guardianship or conservatorship over a person and their estate when the Employee or spouse is appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

IMMIGRATION

Immigration Assistance

This service covers advice and consultation, preparation

of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

INSURANCE MATTERS

Insurance Claims

This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Plan Member's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

PERSONAL INJURY

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

REAL ESTATE MATTERS

Boundary or Title Disputes (Primary Residence)

This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Primary Residence – Tenant Only)

This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Security Deposit Assistance (Primary Residence – Tenant Only)

This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the Plan Attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan on the Participant's primary residence.

Home Equity Loans (Second or Vacation Home)

This service covers the review or preparation of a home equity loan on the Participant's second or vacation home.

Property Tax Assessment (Primary Residence)

This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.

Refinancing of Home (Second or Vacation Home)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.

Sale or Purchase of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Sale or Purchase of Home (Second or Vacation Home)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's second home or vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.

Zoning Applications

This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

TRAFFIC AND CRIMINAL MATTERS

Driving Under the Influence Defense

This service covers representation of the Participant in defense of any driving under the influence or driving while intoxicated charge, including court hearings, negotiation with the prosecutor and trial. It does not cover vehicular homicide. This service does not include any post-sentencing proceeding, probation violation hearing or appeals by either party.

Expungement

Where permitted by law, this service covers the filing of a petition and appearance at any necessary hearing to expunge convictions from a Participant's criminal record.

Habeas Corpus

This service covers the Participant for the preparation of all paperwork needed, and attendance at the hearing to pursue a habeas corpus proceeding to obtain the release of a Participant who is being unlawfully imprisoned.

Juvenile Court Defense

This service covers the defense of a Participant and a Participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Employee only, including services for Parental Responsibility.

Misdemeanor Defense This service covers representation for Participants in defense of any criminal misdemeanor charge except those relating to traffic or driving under influence charges.

Representation includes court hearings, negotiation with the prosecutor and trial. It does not include representation of a felony charge that is subsequently reduced to a misdemeanor. This service also does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.

Traffic Ticket Defense (No DUI)

This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges

This service covers the Participant with representation in proceedings to restore the Participant's driving license.

WILLS AND ESTATE PLANNING

Trusts

This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

This service covers the preparation of a living will for the Participant.

Powers of Attorney

This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate (10% Network Discount)

Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Electronic Estate Documents

This service provides the Participant with access to a digital estate planning platform at an online website. The digital estate planning platform includes facilitation of the selection, completion, and execution of common estate planning documents that include:

- simple wills;
- powers of attorney;
- living wills; and
- other related documents.

Wills and Codicils

This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions

Legal services that are not included on the list of Covered Services in the Definition of Covered Services are “excluded services”. No services, not even a consultation, can be provided for such excluded services. Excluded services include the following:

- Employment-related matters, including Dow or statutory benefits matters;
- Matters involving Dow, MetLife®, their respective affiliates, or Plan Attorneys;
- Matters in which there is a conflict of interest between the Employee and their Spouse or other Dependents in which case services are excluded for the Spouse and such Dependents;
- Appeals and class actions;
- Farm, business or investment matters, matters involving property held for investment or rental, or issues when the participant is the landlord;
- Patent, trademark and copyright matters;
- Costs or fines in connection with the provision of Covered Services by Plan Attorneys or non-Plan Attorneys;
- Frivolous or unethical matters; and
- Matters for which an attorney-client relationship exists prior to the participant becoming eligible for Plan benefits.

Limitations and Conditions

- What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization, such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under the Plan. However, if you are eligible for legal aid or public defender services, you will still be eligible for benefits under the Plan, so long as you meet the eligibility requirements.
- What if you are involved in a legal dispute with your Dependents? You may need legal help with a problem involving your Spouse, Domestic Partner or Dependent Children. In some cases, both you and your Dependent may need an attorney. If it would be improper for one attorney to represent both you and your Dependent, only you will be entitled to representation by a Plan Attorney. Your Dependent will not be covered under the Plan.
- What if you are involved in a legal dispute with another Employee? If you or your Dependents are involved in a dispute with another eligible Employee or that Employee’s Dependents, MetLife will arrange for legal representation with independent and separate counsel for both parties.

- What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Confidentiality, Ethics and Independent Judgment

Your use of the Plan and the Covered Services that you obtain are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. The Plan Administrator will have access only to limited statistical information needed for orderly administration of the Plan. Neither MetLife nor the Plan Attorney is permitted to provide your employer with information about your legal problems or the Covered Services you use under the Plan.

Neither MetLife, the Company nor the Participating Employer will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and they will not receive any further instructions, direction or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife is responsible for all services provided by Plan Attorneys.

You should understand that the Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan.

You have the right to retain at your own expense any attorney authorized to practice law in your state. Nothing in the Plan, this SPD or any other document requires you to retain a Plan Attorney.

Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife at 1-800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

How to Obtain Covered Services

<u>Website</u>

To use MetLaw®, visit the MetLife's member website at members.legalplans.com. To login, enter the last four digits of your Social Security Number and Zip Code. After you login you will jump to a page that is specific for member services. On this page you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number

- ·Life Guide
- Self-Help Documents/Forms

Client Service Center

You may also use MetLaw®, by calling MetLife's Client Service Center at 1-800-821-6400 Monday – Friday 8 a.m. to 7 p.m., Eastern Time. Be prepared to give the last four digits of your Social Security Number and Zip Code. If you are a Spouse or an eligible Dependent Child of an eligible Employee, you will need the last four digits of the Social Security Number and Zip Code of the Employee through whom you are eligible. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about the Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available. Plan Attorneys may not request or accept additional compensation of any nature from you for the provision of Covered Services, except that you will remain responsible for paying any court costs, filing fees, fines, judgments and any payments disbursed to third parties.

If there are no Plan Attorneys available, you will be asked to select your own attorney who is not a Plan Attorney. You may also select a non-Plan Attorney even if there are Plan Attorneys available. In both of these circumstances, MetLife will reimburse you for these non-Plan attorneys' fees in accordance with a set fee schedule described below. The Company, in its settlor capacity, contracted with MetLife to establish the fee schedule. The fee schedule may be amended by MetLife from time to time. Accordingly, please contact MetLife for a copy of the most recent fee schedule.

For services to be covered under the Plan, you or your eligible Dependents must have obtained a Case Number, retained an attorney (either a Plan Attorney or a non-Plan Attorney) and the attorney must begin work on the covered legal matter while you are eligible to participate in the Plan.

PORTABILITY

You can continue your legal services benefit after retiring or terminating employment. To do so, you must contact MetLife's Client Service Center within 30 days of your termination date and indicate that you want to port the benefit. You are responsible for initiating this process within the appropriate time frame. Coverage during the portability period is the same as group

coverage: the plan design and dependent coverage remain the same. Visit members.legalplans.com or call 1-800-821-6400 (Monday – Friday, 8:00 a.m. – 8:00 p.m. ET) for plan details.

To port the benefit:

- Call MetLife's Client Service Center at 800-821-6400. MetLife will send you an enrollment application. You must enroll within 30 days of your termination or retirement.
- Submit the enrollment application and a lump sum payment equal to the applicable monthly rate times the applicable portability period (as determined below) to MetLife within 30 days of receipt of the application. Note: Refunds will not be issued after payment has been submitted.
- Your portability coverage will begin the first day of the month following MetLife's receipt of your payment and approval of your coverage within the applicable deadline. For example, if you received the enrollment application on July 10th and submit the enrollment application and payment to MetLife on July 22nd, then your portability coverage would begin on August 1st. If, however, you submitted the enrollment application and payment on August 5th, then your portability coverage would begin on September 1st.

You are not eligible for portability coverage if:

- Your participation under the Plan ends because your employer ceases to be a Participating Employer. This could happen, for example, if your employer stops sponsoring the Plan or if your employer is acquired by another company that does not sponsor the Plan.
- You are eligible to continue benefits while on a leave of absence, and your participation in the Plan ends while you are on such a leave of absence. For example, your participation in the Plan would end while you are on a leave of absence if you fail to timely pay the required contribution.

EMPLOYEE CONTRIBUTION

You pay the cost of the Plan through after-tax payroll deductions, based on your enrollment choice. The cost of the Plan is available by contacting the Human Resources (HR) Service Center at (833) 693-6947.

ADDITIONAL FUNDING INFORMATION

Employees pay the premiums for Plan coverage. Benefits under the Plan are insured through a group insurance contract with MetLife Legal Plans, Inc. Benefits, if any, that are not paid through a group insurance contract are paid from the Company's or Participating Employer's general assets.

Plan expenses (such as consulting fees, actuarial fees, attorneys' fees, third party administrator fees and other administrative expenses) may be paid by the Participating Employers or from assets of the Plan, if any.

The Plan is funded by insurance underwritten by MetLife and by Employee contributions.

FILING A CLAIM FOR A PLAN BENEFIT

Claims for a Plan Benefit - The Initial Claims Reviewer and the Appeals Administrator are MetLife.

How to File a Claim for Plan Benefits

For Claims for Plan Benefits, the claimant should call MetLife's Client Service Center at 1-800-821-6400, between Monday – Friday 8 a.m. to 7 p.m., Eastern Time. A claimant can also file a Claim for Plan Benefits by logging into MetLife's website, at members.legalplans.com. When you call or log on, please have the company name of your Employer, the last four digits of your Social Security Number, and your home Zip Code available to provide the Client Service Representative or to access your account on the website.

Initial Determinations

If you submit a Claim for Plan Benefits, you must do so as soon as reasonably possible, but not later than twelve months, after the date that Covered Services were performed.

ADDITIONAL DEFINITIONS

Administrator means either the Claims Administrator or the Plan Administrator.

Appeals Administrator means, with respect to reviewing an adverse Claim for Plan Benefits, MetLife. The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the person, group of persons or entity designated by the Plan Sponsor in accordance with the Plan Document. The person, group of persons or entity designated as the Appeals Administrator for Claims for an Eligibility Determination is listed in Section 18.

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

Covered Services means the legal services described in the Definition of Covered Services.

Dependent Child(ren) means a child who is the Participant's natural child (coverage from the moment of birth) or legally adopted child; step-child; or foster child (coverage from the moment of placement in the home), provided that no child shall be recognized as a Dependent Child after the month in which the child turns age 26.

ERISA means the Employee Retirement Income Security Act of 1974, as amended. MetLife means MetLife Legal Plans, Inc.

Initial Claims Reviewer means, with respect to deciding Claims for Plan Benefits, MetLife. The Initial Claim 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 Section 18.

Plan Attorney means a lawyer participating in the Plan's network of participating law firms.

Policy means the group insurance policy that underwrites the benefits provided under the Plan.

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