Summary Plan Description for:

The Dow Chemical Company Long-Term Care Program's

Long-Term Care Insurance Plan

(Applicable to those enrolled on or after July 1, 2007 and prior to 1/1/2012)

Amended and Restated: December 28, 2011
Effective January 1, 2012 and thereafter until superseded.

This Summary Plan Description (SPD) is updated annually on the Dow Intranet.

Copies of this SPD can be found on the Dow Intranet or by requesting a copy from the Human Resources (HR) Service Center, Employee Development Center, Midland, MI 48674, telephone 877-623-8079 or 989-638-8757. Summaries of modifications may also be published from time to time in Dow's Newsline publication or by separate letter.

Content Steward: Theis
January 1, 2012
Literature #318-60515

Table of Contents

Plan Description 2
The Policy 2
Who Is Eligible to Apply for Coverage? 2
John Hancock Determines Whether to Approve Your Application for Coverage 2
Effective Date of Coverage 2
Costs 2
Covered Services 3
I. Nursing Home Care 3
II. Alternate Care Facilities 3
III. Community Based Professional Care (CBPC) 3
IV. Informal Care 3
V. Stay at Home Benefit 3
Excluded Services and Conditions 4
COVERAGE CHOICES / DECISIONS 4
PLAN DECISION 1: Daily Maximum Benefit 4
PLAN DECISION 2: Nonforfeiture Benefit 5
PLAN DECISION 3: Inflation Protection Option 5
ADDITIONAL FEATURES OF THE PLAN ..... **Error! Bookmark not defined.**
Qualifying for Benefit Payment 7
Activities of Daily Living 7
Filing a Claim for Benefits 7
Appealing a Denial of Claim for Benefits 8
Fraud Against the Plan 8
Decertification of Benefit Eligibility 8
Guaranteed Continuation of Coverage 8
Ending Coverage 8
Your Legal Rights 8
Plan Administrator's Discretion 9
Welfare Benefits 10
Dow's Right to Terminate or Amend the Program 10
Disposition of Plan Assets if the Plans are Terminated 10
Funding 10
Class Action Lawsuits 10
For More Information 10
IMPORTANT NOTE 10
ERISA INFORMATION 12
CLAIMS PROCEDURES APPENDIX 13
GLOSSARY OF TERMS 16

This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Long-Term Care Insurance Plan (*applicable to those enrolled on or after July 1, 2007 and prior to January 1, 2012)*. The Dow Chemical Company Long Term Care Insurance Plan (*applicable to those enrolled on or after July 1, 2007 and prior to January 1, 2012)* is a component of The Dow Chemical Company Long Term Care Program.[1]

As used in this Summary Plan Description, references to "Plan" are to The Dow Chemical Company Long-Term Care Insurance Plan (*applicable to those enrolled on or after July 1, 2007 and prior to January 1, 2012*). Reference to "Dow" refers collectively to The Dow Chemical Company and its subsidiaries and affiliates authorized to participate in the Plans. References to "Participating Employer" refer to The Dow Chemical Company or any other corporation or business entity The Dow Chemical Company authorizes to participate in the Plans with respect to its Employees. Words that are capitalized in this Summary Plan Description (SPD) are defined either in this SPD or in the Plan Document for The Dow Chemical Company Long Term Care Program. The SPD is an integral part of the Plan Document. The Plan Document includes this SPD and the Policy underwritten by John Hancock. A copy of the Plan Document, including the Policy, is available upon request of the Plan Administrator identified in the "ERISA Information" section of this SPD.

For further information, contact John Hancock Life Insurance Company at 1-800-582-4369, or if calling outside of the United States, (617) 572-0048.

Important Note: As of January 1, 2012, John Hancock is no longer allowing new enrollees into the Plan.

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

[1] The Dow Chemical Company Long-Term Care Insurance Plan (*applicable to those enrolled prior to July 1, 2007 and prior to January 1, 2012*) is another plan provided under The Dow Chemical Company Long Term Care Program. It also has an SPD.

Long-Term Care Insurance Plan Highlights

Under This Plan, You:	**When:**
Can enroll only between July 1, 2007. and December 31, 2011	No new applications accepted after December 31, 2011 for this Plan.
Pay for coverage for you and your Spouse/Domestic Partner.	You authorize regular payroll deductions for this purpose. Retirees and dependents pay through direct billing or automatic bank withdrawal.
Become insured.	Your application for coverage is accepted if you enrolled prior between July 1, 2007 and December 31, 2011. Coverage is effective the first day of the month following application approval or on January 1, if approved during an annual enrollment period prior to December 31, 2011, provided you are actively at work on that date or, in the case of a retiree or dependent, are not disabled, and are still a member of the eligible class.
Are eligible to receive benefits.	You are certified as cognitively impaired or to need the substantial assistance of another person in order to perform at least two of six significant Activities of Daily Living (SADLs), due to a loss of functional capacity for a period which is expected to last at least 90 days and you complete the 60-day Qualification Period.

Plan Description

The Dow Chemical Company Long-Term Care Insurance Plan (applicable to those enrolled on or after July 1, 2007 and prior to January 1, 2012) ("Plan") is a long-term care plan insured by an insurance policy ("Policy") underwritten by John Hancock Life Insurance Company ("John Hancock"). The Plan is offered to make available to you and your eligible family member's insurance coverage to help pay for the cost of services associated with long-term care needs. LTC insurance may help protect your assets in the future. The Plan provides five coverage options for nursing home care and other related services such as home health care and adult day care. Premiums are based on your Issue Age when you apply for coverage. In addition, the Plan provides valuable information and advice. Case managers help you identify long-term care resources and advise you on the level of care and type of site appropriate for your circumstances.

The same services are covered under each of the five coverage options, with varying benefit amounts. Your benefit amounts are determined by the option you select.

Note: As of January 1, 2012, John Hancock is no longer allowing new enrollees into the Plan.

The Policy

Any conflicts between the Policy issued by John Hancock and the body of this SPD shall be resolved in favor of the Policy. The policy is hereby incorporated by reference into this SPD and made a part of the SPD.

Who Is Eligible to Apply for Coverage?

As of January 1, 2011, no new applications for coverage under the Plan are accepted. The eligibility requirements set forth in the SPD amended and restated December 1, 2010 apply to those who were enrolled prior to January 1, 2012.

John Hancock Determines Whether to Approve Your Application for Coverage

After you have submitted your application for coverage, John Hancock will determine whether to approve your application for coverage. If John Hancock does not approve your application for coverage under the Policy, then you are not covered under The Dow Chemical Company Long-Term Care Plan.

Effective Date of Coverage

A person who has been accepted by John Hancock on or after July 1, 2007 and prior to January 1, 2012, for coverage under the Policy is "enrolled" in the Plan.

For those who enrolled in the Plan on or after July 1, 2007 and prior to January 1, 2012, the effective date of coverage is described in the SPD amended and restated December 1, 2010.

Costs

Your premiums are based on your "Issue Age"---- your actual age on the later of the new plan effective date, benefit eligibility date or the date the application is received by John Hancock. The cost will not be increased later because of age, illness, or use of benefits. For instance, if you are 45 when you are accepted for coverage, your premiums for the coverage level you elect now will always be based on age 45 as long as you pay your premium when due. Premiums will be adjusted only if they are changed for an entire group of people, you elect a change in coverage, a change is required by law or if you elect to purchase the Inflation Adjustment Feature offered.

The cost for your coverage is paid entirely by you. Ask John Hancock whether the payroll deduction feature is available to you. Dow does not underwrite any of the costs, including administrative fees, for coverage under this Plan.

Retirees and their Spouses/Domestic Partners, parents and parents-in-law who are enrolled are billed directly by John Hancock.

If your effective date of coverage is postponed because the active employee is not actively at work or the retiree or eligible dependent is disabled on the date the insurance would otherwise have become effective, your premium will be based on your age on your actual effective date.

Covered Services

The following services are covered under the Plan:

I. Nursing Home Care

Skilled, intermediate or custodial care provided to you by a qualified nursing facility while an inpatient.

II. Alternate Care Facilities

Covered services provided to you by a qualified Alternate Care Facility while an inpatient.

III. Community Based Professional Care (CBPC)

A) Home Health Care provided in your home

Home nursing care that you receive from a registered nurse or licensed practical nurse or licensed vocational nurse.

Physical, respiratory, occupational or speech therapy provided by professionals licensed in their field of practice.

Home health aide services you receive in your home from persons who are certified or employed by qualified home health care agencies. Home Health Care services provided by a person who ordinarily resides in your home are not covered.

B) Adult Day Care

Physical and social support services provided by a qualified adult day care center. Adult day care services provided by a person who ordinarily resides in your home are not covered.

C) Hospice Care provided in your home by a qualified Hospice.

D) Homemaker Services provided in your home by persons who are certified or employed by qualified home health care agencies.

IV. Informal Care

Services designed to provide help with everyday activities, personal supervision for protection of a cognitively impaired insured, or maintaining the home environment. Informal services provided by a person who ordinarily resides in your home can be covered if the provider is 18 years of age or older, or certified or employed through a qualified home health care agency. There is a calendar year maximum for Informal Care Services equal to 30 times 25 percent of the Nursing Home Daily Maximum Benefit of the option you select.

V. Stay at Home Benefit

Stay at Home Benefit can be used to pay for the following expenses:

- Care Planning Visits
- Caregiver Training
- Home Safety Check
- Emergency Medical Response System
- Home Modification
- Durable Medical Equipment
- Provider Care Check

The Stay at Home Benefit is the most the plan will pay for the cost of all covered stay at home services received while you are insured, and will not exceed 30 times your DMB. The Stay at Home Benefit is available during the Qualification Period and does not reduce your LMB.

The Stay at Home benefit amount will be recalculated whenever your DMB changes due to inflation increases, benefit increases, and decreases provided you have not exhausted this benefit. Any benefits paid out will be subtracted from the recalculated amount. Except for the Care Planning Visit, you must be residing in your home to be eligible. The maximum amount payable for Caregiver Training will not exceed 5 times your DMB.

Excluded Services and Conditions

John Hancock will not pay benefits for charges incurred by the insured for:

- Conditions resulting from the following:
  - Your intentionally self-inflicted injury
  - War, whether declared or not, or any act of war, or service in any armed forces or auxiliary units
  - Your commission of or attempt to commit a felony
  - Your engaging in an illegal occupation
  - Your participating in an insurrection or riot
- Care, services or treatment specifically provided for detoxification or rehabilitation for alcohol or drug addition.
- Charges normally not made in the absence of insurance.
- Except under the Informal Care Benefit, care, treatment or charges provided by a member of your immediate family or by a person who ordinarily resides in your home. Minor exceptions apply.
- Any service or supply to the extent that charges for it are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance or co-payment amount under Medicare. This exclusion will not apply in those instances where Medicare is determined to be secondary payor under applicable law; or
- Care, services or supplies furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except as required by law and except:
  1. a program established by the Federal government for its civilian employees
  2. Medicare, and
  3. Medicaid (This mean any state medical assistance program under Title XIX of the Social Security Act as amended from time to time).

No benefit is payable under the policy for care received outside the United States (50 states and the District of Columbia) except as described in International Benefits.

These exceptions may not apply in all states and may vary depending on the state in which you live.

COVERAGE CHOICES / DECISIONS

PLAN DECISION 1: Daily Maximum Benefit

You may choose your Daily Maximum Benefit (DMB) from the options listed below. The DMB is the most the insurance may pay for all covered serviced received on any day. Each option has a corresponding Lifetime Maximum Benefit (LMB). The LMB is the total pool of money payable for covered services received while you are insured, except for the Stay at Home Benefit, which is not included as part of this pool.

DMB Option	Nursing Home DMB	Alternate Care Facility[2] DMB	Community Based Professional Care[3] DMB	Informal Care[4] DMB	Lifetime Maximum Benefit
$100	$100.00	$100.00	$75.00	$25.00	$182,500
$150	$150.00	$150.00	$112.50	$37.50	$273,750
$200	$200.00	$200.00	$150.00	$50.00	$365,000
$250	$250.00	$250.00	$187.50	$62.50	$456,250
$300	$300.00	$300.00	$225.00	$75.00	$547,500

[1] If you are a resident of Kansas, this benefit varies slightly.

[2] This includes Adult Day Care and the following services provided in your home: Home Health Care, Hospice Care and Homemaker Services that are provided by a person who is certified or employed through a licensed Home Health Care Agency.

[3] The total of benefits payable for all informal care received in any calendar year is 30 times the Informal Care DMB.

PLAN DECISION 2: Nonforfeiture Benefit

You have the choice of including a Nonforfeiture Benefit (Reduced Lifetime Maximum Paid-Up Benefit) in your coverage at enrollment for an additional cost. If you do not elect this option, the Contingent Nonforfeiture Benefit will be included in your coverage at no additional cost.

Nonforfeiture Benefit
(Reduced Lifetime Maximum Paid-up Benefit) Option

This benefit will allow you to stop making premium payments for any reason and retain a reduced level of coverage if you have been continuously insured under the plan for at least three years. If you exercise this benefit, your coverage will be in a reduced paid-up status, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of 30 times your DMB or the sum of premiums paid in. If you exercise this benefit after a minimum of 10 years of continuous coverage, the reduced LMB would be equal to the greater of 90 times the DMB or the sum of premiums paid in.

Contingent Nonforfeiture Benefit

This benefit can only be exercised in the event of a substantial premium increase. It allows you to stop premium payments and keep a reduced level of coverage. If you exercise this benefit, your coverage will be in reduced paid-up status, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of: the total amount of premiums paid for your insurance since coverage was issued, or 30 times your DMB. A substantial premium increase would range from 10% at Issue Age 90 or older to 200% at Issue Age 20 or younger.

PLAN DECISION 3: Inflation Protection Option

You can include the Automatic Benefit Increase (ABI) Inflation Protection Provision at enrollment for an additional cost. If you do not elect this option, the Future Purchase Option Provision will be included in your coverage.

Automatic Benefit Increase (ABI)

Under this option, increases to your benefit amounts occur automatically each year. Every July 1, beginning July 1, 2008, the DMB amount will increase at an annual rate of 5% compounded, with no annual increase to your premium. The LMB will increase in proportion to the increase in the Nursing Home DMB. If your insurance becomes effective on July 1, no increase will apply on your effective date of coverage. The benefit increase will continue to be made annually regardless of your age or whether you have met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop premium payment and continue coverage in effect on a reduced paid-up basis under the Nonforfeiture Benefit.

Future Purchase Option
Under this option, you will be offered additional amounts of coverage every three years to keep up with inflation. The amount of each adjustment will reflect a benefit increase to the DMB of at least 5% compounded annually for the applicable period. The LMB will increase in proportion to the increase in the Nursing Home DMB. The premium rates for the inflation increases will be based on your Issue Age on the effective date of the increase. They will also include an additional charge to account for the added risk associated with permitting you to buy additional coverage without having to submit proof of good health. An inflation adjustment will not be available if you are Issue Age 85 or older, or if you have met the benefit eligibility requirements under the policy in the six months prior to the increase effective date, or if coverage is in reduced paid-up status under the Nonforfeiture Benefit. *(If you are a resident of Connecticut, Delaware, Indiana, or Kansas, this provision varies slightly. Call John Hancock at 1-800-582-4346 for details).*

Additional Features of the Plan

Coordination of Benefits
Any benefits payable under the Long-Term Care Insurance Plan will be coordinated with other forms of coverage but not with individual policies or Medicaid.

Bed Reservation Benefit
The plan will continue to pay nursing home or alternate care facility benefits for up to 60 days per calendar year if you leave the facility on a short-term basis while receiving plan benefits.

Restoration of Benefits
The Restoration of Benefits feature allows you to restore your LMB if you provide proof that you:

- Have not met the benefit eligibility criteria during the 24-month period up to and immediately proceeding the date you request to restore your LMB,
- Have not exhausted your LMB, and
- Have been continuously insured on a premium-paying basis during the 24 months just prior to the date of your request

Restoration of Benefits does not apply if coverage is in reduced paid-up status under the Nonforfeiture Benefit.

International Benefits
This plan will pay actual charges incurred for any day of covered services, up to the International Daily Maximum Benefit, if the following conditions are met:

- You are permanently residing outside the U.S. (50 dates and DC)
- You provide John Hancock with proof of benefit eligibility, including certification by a licensed health care practitioner (LHCP) that you require substantial assistance from another person in performing at least two of the six ADL's due to a loss of functional capacity that is expected to last for at least 90 days or that you have a severe cognitive impairment that requires substantial supervision.
- Services are based on a plan of care prescribed by a LHCP.
- The Qualification Period has been met.
- You continue to meet the benefit eligibility requirements under the policy.

Each level of benefits will be paid up to 75% of the amount that would apply in the U.S. The total of benefits payable for all charges incurred on any day will not exceed the International Daily Benefit Maximum, which is equal to 75% of the Nursing Home DMB. All documentation provided to John Hancock must be in English. The benefit will be paid directly to the insured or his or her legal representative. Benefit payment will be made in U.S. currency, based upon the exchange rate effective on the last day of the month in which covered services were received.

The Stay at Home Benefit and Respite Care are not available to insured persons residing outside the U.S. Coordination of Benefits does not apply. No benefit is payable during the Qualification Period. No benefit is payable under the policy for care received outside the U.S. (all 50 dates and the District of Columbia) except as provided in the International Benefits Provision).

Waiver of Premium
Your premium payments will be waived on the first day of the month after you complete the Qualification Period, provided you meet the benefit eligibility requirements under the policy on that date. The waiver will continue as long as you remain eligible for benefits.

Portability
If you retire or leave Dow, your coverage will be continued at group rates. You will pay premiums directly to John Hancock.

Alternate Plan of Care
An alternate plan of care can be established by mutual agreement between you, a licensed Health Care Practitioner and John Hancock if the John Hancock Care Coordinator identifies alternatives to the current plan that are both appropriate for you and cost-effective. It may provide benefits for services or supplies not otherwise covered by the plan. Any benefits paid under an alternate plan of care will reduce the LMB.

Qualifying for Benefit Payment

A licensed health care practitioner must certify that you require substantial assistance (hands on or stand by) from another person to perform at least two Activities of Daily Living (ADLs) due to loss of functional capacity, which is expected to continue for at least 90 days or that you need substantial supervision due to a cognitive impairment. You become eligible for benefits when a John Hancock Care Coordinator verifies that you meet the benefit eligibility requirements under the policy, and you have completed the 90 day Qualification Period.

Activities of Daily Living

There are six Activities of Daily Living (ADLs) which are used to determine your eligibility for benefits:

- Bathing
  Means washing oneself in either a tub or shower, including the task of getting into or out of the shower.
- Dressing
  Means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating
  Means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting
  Means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring
  Means moving into or out of a bed, chair or wheelchair.
- Maintaining Continence
  Means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Filing a Claim

To file a Claim, see the *Claims Procedures Appendix* of this SPD. John Hancock is the Claims Administrator, and a named fiduciary of the Plan.

Appealing a Denial of Claim

If you want to appeal a denial of claim, you can file an appeal. See *the Claims Procedures Appendix* of this SPD. John Hancock is the Claims Administrator, and a named fiduciary of the Plan.

Fraud Against the Plan

Any Plan Participant who intentionally misrepresents information to the Plan or knowingly misinforms, deceives, or misleads the Plan, or knowingly withholds relevant information, may have his/her coverage cancelled retroactively to the date deemed appropriate by the Plan Administrator. Further, such Plan Participant may be required to reimburse the Plan for Claims paid by the Plan. The Plan may choose to pursue civil and/or criminal action. The Plan Administrator may determine that the Participant is no longer eligible for coverage under the Plan because of his or her actions.

Decertification of Benefit Eligibility

When your claim is first received, the case manager reviews Plan provisions with you including your Maximum Benefit amounts and ADL dependency or cognitive impairment requirements. Your need for long-term care is periodically reviewed. An improvement in your condition could mean that you are no longer dependent according to ADL or cognitive impairment requirements. The case manager will keep you informed about your progress as it relates to your eligibility for benefits.

When the case manager who works for John Hancock determines that ADL dependency requirements are no longer met, you will be decertified and your benefit period will end. You may appeal this decision. See the *Claims Procedures Appendix* of this SPD. If you have any questions concerning the cessation of benefits, contact John Hancock at 1-800-582-4369.

Guaranteed Continuation of Coverage

Once you are insured in the Plan, your coverage may remain in effect based on the terms of the Policy, even if you are no longer affiliated with Dow or a Participating Employer. Your premiums must be paid on time and all other Plan requirements remain the same. You will be direct-billed when you are no longer eligible for payroll deductions.

Ending Coverage

Participants enrolled in the Plan may terminate coverage at any time during the year by written notification to John Hancock. Coverage is terminated at the end of the month in which such notification is received.

If you fail to pay a required premium when due, coverage will end on the premium due date for which premium remains unpaid. Coverage will end if you exhaust your Lifetime Maximum Benefit Amount.

If the Policy is terminated, you may continue your coverage under a replacement policy issued by a succeeding insurer or under a group policy issued by John Hancock. If Dow discontinues the Plan, you may continue your coverage under a conversion policy issued by John Hancock.

Your Legal Rights

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan Document and the latest annual report filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of the Plan Document and Summary Plan Description. The Administrator may charge a reasonable fee for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

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

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

Enforce your rights: Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you must file a written appeal within the time period specified in the Plan's Claims Procedures. Failure to comply with the Plan's claims procedures may significantly jeopardize your rights to benefits. If you are not satisfied with the final appellate decision, you may file suit in Federal court.

Deadline to file a lawsuit: **If you file a lawsuit, you must do so within 120 days from the date of the Claims Administrator's or the Plan Administrator's final written decision (or the deadline the Claims Administrator or Plan Administrator had to notify you of a decision). Failure to file a lawsuit within the 120 day period will result in your waiver of your right to file a lawsuit.** 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.

If it should happen that plan fiduciaries misuse the Plan's money, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. **If you file a lawsuit, you must do so within 120 days from the date of the alleged misuse. Failure to file a lawsuit within the 120 day period will result in your waiver of your right to file a lawsuit.**

Assistance with your questions: If you have any questions about the Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administrator's Discretion

The Plan Administrator is a fiduciary to the Plan. Except for the duties reserved to the Claims Administrator, the Plan Administrator has the full and complete discretion to interpret and construe all of the provisions of the Plan. Such interpretation of the provisions of the Plan shall be final, conclusive and binding. Except for the duties reserved to the Claims Administrator, the Plan Administrator also has the full and complete discretion to make findings of fact. The Plan Administrator has the full authority to apply those findings of fact to the provisions of the Plan. All findings of fact made by the Plan Administrator shall be final, conclusive and binding. For a detailed description of the Plan Administrator's authority, see

the Plan Document. See Claims Procedures Appendix for information about the Claims Administrator's discretion.

Welfare Benefits
Welfare benefits, such as the Long-Term Care Insurance Program, are not required to be guaranteed by a government agency.

Dow's Right to Terminate or Amend the Program
The Dow Chemical Company reserves the right to amend, modify, or terminate the Plan at any time at its sole discretion. The procedures for amending, modifying, or terminating the Plan are contained in the Plan Document.

Disposition of Plan Assets if the Plans are Terminated
The Dow Chemical Company may terminate The Dow Chemical Company Long Term Care Program ("Program"), including any underlying plans, at any time at its sole discretion. If The Dow Chemical Company terminates the Program, the assets of the Program, if any, shall not be used by The Dow Chemical Company, but may be used in any of the following ways:

(1) to provide benefits for Participants in accordance with the Program, and/or
(2) to pay third parties to provide such benefits, and/or
(3) to pay expenses of the Plan and/or the Trust holding the Program's assets, and/or
(4) to provide cash for Participants, as long as the cash is not provided disproportionately to officers, shareholders, or Highly Compensated Employees.

Funding
The Plan is funded by an insurance policy underwritten by John Hancock Life Insurance Company.

Class Action Lawsuits
Legal actions against the Plan or Program must be filed in federal court. Class action lawsuits must be filed either 1) in the jurisdiction in which the Plan is administered (Michigan) or 2) the jurisdiction where the largest number of putative members of the class action reside. This provision does not waive the requirement to exhaust administrative remedies before the filing of a lawsuit.

For More Information
If you have questions about LTC insurance benefits or enrollment, contact John Hancock at (800)582-4369. You can also call the HR Service Center at the number listed in the *ERISA Information section* of this SPD for general plan information.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Long-Term Care Insurance Plan. The SPD and the insurance policy are integral parts of the Plan Document. The SPD is not all-inclusive and it is not intended to take the place of the Plan Document. In case of conflict between this SPD and the Plan Document, the Plan Document will govern. The Plan's fiduciaries have the sole discretion to interpret the provisions of the Long-Term Care Insurance Program, including its underlying plans, and the sole discretion to make finding of fact. Interpretations, eligibility and claims decisions made by the plan fiduciaries will be final and binding on Participants.

The Dow Chemical Company reserves the right to amend, modify or terminate the Long-Term Care Insurance Program, including its underlying plans, at any time at its sole discretion. The procedures for amending the Plan are contained in the Plan Document for the Long-Term Care Insurance Program.

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

This SPD and the Plan do not constitute a contract of employment. Dow retains the right to terminate your employment or otherwise deal with your employment as if this Benefits Guide and the Plan had never existed. The Dow Chemical Company retains the right to amend any aspect of any plan or to terminate any plan at its discretion.

All provisions described herein may vary subject to your applicable collective bargaining agreement.

ERISA INFORMATION
LONG-TERM CARE INSURANCE PLAN

Plan Sponsor:	The Dow Chemical Company Employee Development Center Midland, MI 48674 1-877-623-8079
Claims Administrator:	John Hancock Life Insurance Company Group Long-Term Care Department, B-6 P.O. Box 111 Boston, MA 02117-0111
Employer I.D. #:	38-1285128
Plan Number:	560
Group Policy Number:	28925-LTC
Plan Administrator:	N.A. Health and Welfare Leader The Dow Chemical Company Employee Development Center Midland, MI 48674 1-877-623-8079
To Initiate the Claim Process:	See Claims Procedures Appendix of this SPD.
To Appeal a Benefit Eligibility Determination:	See Claims Procedures Appendix of this SPD.
To Serve Legal Process, File With:	General Counsel The Dow Chemical Company Corporate Legal Department 2030 Dow Center Midland, MI 48674
Plan Year:	The Plan's fiscal records are kept on a Plan year beginning January 1 and ending December 31
Funding:	Plan participants pay the entire cost of the coverage. Plan assets may be held in the Dow Chemical Company Employees' Welfare Benefit Trust. 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, attorney's fees, third party administrator fees and other administrative expenses.

CLAIMS PROCEDURES APPENDIX TO THE
Long-Term Care Plan Summary Plan Description

A "Claim" is a written request by a claimant for a benefit under the Plan. In order to be a properly filed "Claim", the claimant must follow the procedures described in this Appendix.

Who Will Decide Whether to Approve or Deny My Claim?

John Hancock is the Claim Administrator and a named fiduciary of the Plan. John Hancock decides whether to approve or deny claims.

Authority of the Claims Administrator and Your Rights Under ERISA

John Hancock is the Claims Administrator of the Plan and has the full, complete, and final discretion to interpret the provisions of the insurance policy and to make findings of fact in order to carry out its Claims decision-making responsibilities.

Interpretations and claims decisions by the Claims Administrator are final and binding on Participants. If you are not satisfied with the Claims Administrator's final appellate decision, you may file a civil action against the Plan under s. 502 of the Employee Retirement Income Security Act (ERISA) in a federal court. **If you file a lawsuit, you must do so within 120 days from the date of the Claim Administrator's final written decision. Failure to file a lawsuit within the 120 day period will result in your waiver of your right to file a lawsuit.**

An Authorized Representative May Act on Your Behalf

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

HOW TO FILE A CLAIM

You must complete and send a Certification of Need form to:

John Hancock Life Insurance Company
Group Long-Term Care Department, B-6
P.O. Box 111
Boston, MA 02117-0111
1-800-582-4369
Attention: Clams Administrator for The Dow Chemical Company Long-Term Care Plan

You can obtain a Certification of Need Form by calling John Hancock at 1-800-582-4369. When the John Hancock case manager calls you, you should explain that you want to file a Claim. The case manager will explain the certification process, go over the Plan with you, and begin to gather information about your care needs. The case manager will send you a Certification of Need Form.

How Your Claim Will Be Processed by John Hancock

- Once you have completed and submitted a Certification of Need form to John Hancock, John Hancock will review and notify you in writing of its decision. The notice must be given to you within a reasonable period, not to exceed 90 days; except that under special circumstances, John Hancock may have up to an additional 90 days. If John Hancock 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 John Hancock determines that it does not have sufficient

information to make a decision on your Claim, it will notify you and describe any additional material or information necessary for you to submit to the Plan and the deadline for submitting such information.

- As part of the process of reviewing your Claim, the John Hancock case manager will send your physician a Physician's Certification Form and will contact other health care providers and family members to obtain additional information.
- If there is uncertainty about your dependency in performing the ADLs or your cognitive dependency, the case manager contracts with a local nurse or other health care professional to perform an on-site assessment. The assessor submits a telephone report and a completed Field Assessment Form to the case manager.
- The case manager determines if you meet the ADL dependency or cognitive impairment requirement, based on all of the information provided.
- The case manager may recommend the type of site and level of care appropriate for you. You are not required to follow these recommendations.
- Once the case manager certifies that you are ADL dependent or cognitively impaired, you will receive a letter affirming your eligibility for benefits. This letter provides the date of certification, the length of your Qualification Period and the date that you will be eligible for benefit payment if you remain certified.
- After successful completion of the Qualification Period, your premiums are waived while you remain certified. Benefit payment can be made directly to you or may be assigned to a provider whose services are covered under the Plan.
- The case manager determines how frequently a reassessment of your condition should be conducted. Reassessment is performed at least annually, but may be required as often as once per month.

If Your Claim Is Denied

If the case manager determines that you do not meet the certification requirements for ADL dependency or determines that you are not cognitively impaired, the case manager will notify you in writing. The letter will explain why the Claim was denied and refer to the pertinent Plan provision(s).

If You Want to Appeal a Denial of Your Claim

Within 60 days of the denial of claim notice, send a letter stating that you are appealing the denial to:

Director of Case Management
John Hancock Life Insurance Company
Group Long-Term Care Department, B-6
P.O. Box 111
Boston, MA 02117-0111
1-800-582-4369
Attention: Claims Administrator for The Dow Chemical Company Long-Term Care Plan
(Appellate Review)

You must include the following information in your letter:

- Employee's name
- Employee number
- Employee's social security number
- Insured's name
- Insured's social security number
- Name of the benefit Plan (The Dow Chemical Company Long-Term Care Insurance Plan, Policy Number 27182 – LTC)
- Explain the reason for the appeal

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

After John Hancock receives your written request to appeal the initial determination, John Hancock will review your Claim de novo. Deference will not be given to the initial adverse decision, and the appellate reviewer will look at the Claim anew. The person who will review your appeal will not be the same person as the person who made the initial decision to deny the claim. In addition, the person who is reviewing the appeal will not be a subordinate who reports to the person who made the initial decision to deny the Claim. John Hancock 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, John Hancock may have up to an additional 60 days to provide written notification of the final decision. If John Hancock 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 John Hancock determines that it does not have sufficient information to make a decision on the Claim prior to the expiration of the initial 60 day period, it will notify you. It will describe any additional material or information necessary to submit to the Plan, and provide you with the deadline for submitting such information. The initial 60 day time period for John Hancock to make a final written decision, plus the 60 day extension period (if applicable) are tolled from the date the notification of insufficiency is sent to you until the date on which it receives your response. ("Tolled" means the "clock or time is stopped or suspended". In other words, the deadline for John Hancock to make its decision is "put on hold" until it receives the requested information). The tolling period ends when John Hancock receives your response, regardless of the adequacy of your response.

If John Hancock has determined to that its final decision is to deny your Claim, the written notification of the decision will state the reason(s) for the denial and reference the pertinent Plan provision(s).

GLOSSARY OF TERMS
See also the Plan Document and the Policy for additional defined terms.

Actively at Work
"Actively at work" means that the Employee reports to work with the Participating Employer at his or her usual place of employment. The usual place of employment must be outside of the Employee's home. An Employee must also be able to perform all the usual and customary duties of his or her occupation on a regular full-time basis. If an employee does not so report or if the usual place of employment is in the home, he or she can still be considered to be actively at work. However, the Employee cannot, at any time on the date in question, be:

- A hospital patient, or
- Disabled to a degree that he or she could not then have reported to a place of employment outside of the home and performed all of the usual and customary duties of his or her occupation on a regular full-time basis.

Activities of Daily Living
Activities are limited to: bathing, eating, toileting, dressing, transferring and continence.

Appeals Administrator
The person,group of persons, or entity responsible for reviewing adverse benefit determinations under the Program, as described in DOL Reg. s. 2560.503-1(h). The Appeals Administrator with respect to reviewing an adverse Claim for an Eligibility Determination is the John Hancock Life Insurance Company. The Appeals Administrator with respect to reviewing an adverse Claim for Plan Benefits is the John Hancock Life Insurance Company. The Appeals Administrator is a named fiduciary.

Claim
A written request for a plan benefit or an Eligibility Determination that contains, at a minimum, the information described in the Claims Procedures Appendix.

Claim for an Eligibility Determination
A Claim requesting a determination as to whether a claimant is eligible for coverage under the Plan.

Claim for a Plan Benefit
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.

Cognitive Impairment
Cognitive Impairment is deterioration or loss of intellectual capacity that is comparable to and includes Alzheimer's Disease and similar forms of irreversible dementia. The need for substantial supervision due to severe cognitive impairment must be established by clinical evidence and standardized tests that reliably measure impairment in a person's short-term or long-term memory; orientation as to person, place, or time; or deductive or abstract reasoning, or judgment as it relates to safety awareness.

Daily Maximum Benefit (DMB)
The most the insurance may pay for all covered services received on any day.

Initial Claims Reviewer
The person, group of persons or entity responsible for deciding claims under the Plan, as described in DOL Reg. s. 2560.503-1(e). The Initial Claims Reviewer with respect to deciding a Claims for an Eligibility Determination is the John Hancock Life Insurance Company. The Initial Claims Reviewer with respect to deciding Claims for Plan Benefits is the John Hancock Life Insurance Company.

Issue Age
Actual age on the later of the new plan effective date, benefit eligibility date or the date the application is received by John Hancock.

Lifetime Maximum Benefit (LMB)
The total pool of money payable for covered services received while you are insured, except for the Stay at Home Benefit, which is not included as part of this pool.

Qualification Period
The Qualification Period is the period of time you must wait from the date John Hancock verifies that you meet the benefit eligibility requirements under the policy until the date benefits are payable for covered charges you incur. The Qualification Period is 90 days and needs to be met only once as long as you remain continuously insured. No expenses need to be incurred during this period of time. You must remain eligible for benefits during this period, but you don't have to receive long-term care services or be hospitalized. The policy will pay benefits for covered charges you incur after the Qualification Period is met as long as you remain eligible for benefits.

Plan
As referred to in this SPD, Plan means The Dow Chemical Company Long-Term Care Insurance Plan (applicable to those enrolled on or after July 1, 2007).

Plan Document
The plan document for The Dow Chemical Company Long Term Care Program, which is ERISA Plan #560. The summary plan descriptions and the insurance policies for the plans offered under the Program are integral parts of the Plan Document for the Program.

Program
The Dow Chemical Company Long Term Care Program, which is ERISA Plan #560. The Program comprises several different plans, including The Dow Chemical Company Long-Term Care Insurance Plan (applicable to those enrolled on or after July 1, 2007).

Summary Plan Description (SPD)
The summary plan description for The Dow Chemical Company Long Term Care Program, including its appendices. The summary plan description is an integral part of the Plan Document.