Summary Plan Description for:

The Dow Chemical Company Long-Term Care Program's

Long-Term Care Insurance Plan

(*Applicable to those enrolled prior to July 1, 2007)*

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Effective January 1, 2012 and thereafter until superseded.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

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This booklet is the Summary Plan Description ("SPD") for The Dow Chemical Company Long-Term Care Insurance Plan *(Applicable to those enrolled prior to July 1, 2007)*. The Dow Chemical Company Long-Term Care Insurance Plan *(Applicable to those enrolled prior to July 1, 2007)* 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 prior to July 1, 2007).* References to "Dow" refer 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.

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 *on or after July 1, 2007and prior to January 1, 2012*) is another plan provided under The Dow Chemical Company Long-Term Care Program. It has its own SPD.

Long-Term Care Insurance Plan Highlights

Under This Plan, You:	**When:**
Can enroll only until June 30, 2007.	No new applications accepted after June 30, 2007 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 to July 1, 2007. 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 July 1, 2007, 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 prior to July 1, 2007*) ("Plan") is a Long-Term care plan insured by an insurance policy ("Policy") underwritten by John Hancock Life Insurance Company ("John Hancock"). **The Plan was offered prior to July 1, 2007. As of July 1, 2007 no new applications or enrollments are accepted under the Plan.**

The Long-Term Plan provides three 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. Your issue age is your age on your birthday closest to the date your application is received by John Hancock. 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 three coverage options, with varying benefit amounts. Your benefit amounts are determined by the option you select.

Who Is Eligible to Apply for Coverage?

As of July 1, 2007, no new applications for coverage under the Plan are accepted. The eligibility requirements set forth in the SPD amended and restated October 1, 2006 apply to those who were enrolled prior to July 1, 2007. A person may not be enrolled in this Plan and also enroll in the Long-Term Care Insurance Plan *(Applicable to those enrolled on or after July 1, 2007 and prior to January 1, 2012)* at the same time.

Effective Date of Coverage

For those who enrolled in the Plan prior to July 1, 2007, the effective date of coverage is described in the SPD amended and restated October 1, 2006.

Costs

Your premiums are based on your "issue age"---- your age on your birthday closest to the date your 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, through regular post-tax payroll deductions. If your Spouse/Domestic Partner is enrolled, that contribution is also paid through a payroll deduction from your paycheck. 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.

Covered Services

The following services are covered under the Plan:

Nursing Home Care
Skilled, intermediate or custodial care provided to you in a qualified nursing facility while an inpatient.

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

Home Health Care
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 for 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.

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.

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 will not be covered. There is a calendar year maximum for Informal Care Services equal to 21 times 25 percent of the Nursing Home Daily Maximum Benefit of the option you select.

Excluded Conditions or Services

Charges incurred for the following are not covered by the Plan:

- Mental or emotional disorders without demonstrable organic disease. This includes, but is not limited to: neurosis, psycho-neurosis, psychopath and psychosis. This exclusion does not apply to Alzheimer's disease or other organically caused brain disorders.
  Intentionally self-inflicted injury.
  Care specifically provided for detoxification of, or rehabilitation for, alcohol or drug abuse.
  Conditions caused by:
  - Committing or attempting to commit a felony.
  - Engaging in an illegal occupation.
  - Participating in an insurrection or riot.
  - War (declared or undeclared) or any act of war.
  - Service in any armed forces or auxiliary units.

  Care or treatment provided outside the United States. The United States includes only the 50 states and the District of Columbia.
- A service or supply furnished primarily to beautify.
- A service or supply furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except:
  - A program established by the federal government for its civilian employees.
  - Medicare.
  - Medicaid (any state medical assistance program under Title XIX of the Social Security Act).
- A service or supply for which a charge would not have been made in the absence of insurance.

Please note: These exclusions may not apply in all states and may vary depending on where you live. The certificate of insurance you receive will outline the exact exclusions for your particular state.

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.

Coverage Amounts

The amount of your coverage depends on the option you choose. The Plan pays the covered charges you incur on any day up to the applicable percentage of the Daily Maximum Benefit (DMB) amount. There are three options available. If you enroll on or after January 1, 2005, the DMB and LMB set forth below are available under Option 1, 2, and 3 of either the Comprehensive Coverage or Enhanced Coverage [2]

Comprehensive Coverage

	DMB	LMB
Option 1	$115	$83,950
Option 2	$170	$124,100
Option 3	$255	$186,150

Enhanced Coverage

	DMB	LMB
Option 1	$115	$209,875
Option 2	$170	$310,250
Option 3	$255	$465,375

The amount the plan pays out depends on your coverage choice (DMB), the cost of care, and the setting in which you receive care, based on the following scale.

Nursing Home	Up to 100% of your DMB
Alternate Care Facility	Up to 75% of your DMB
Home Care/Adult Day Care	Up to50% of your DMB
Informal Care[3]	25% of your DMB

Inflation Adjustment Feature

The Plan includes an inflation adjustment feature which permits you to periodically increase your Daily Maximum Benefit amounts to help keep up with the effect of inflation on long-term care costs.

If you take an inflation adjustment increase when it is offered:

- The premium for the additional amount of coverage is based on your issue age when the increase is effective.
- Your premium for the coverage you elected initially is not affected.
- Your Lifetime Maximum Benefit (LMB) increases proportionately, based on the amount of the inflation adjustment increase.

Increases will not be available to you if your "issue age" is age 85 or older or if you are certified as being cognitively impaired or dependent in two or more Significant Activities of Daily Living during the six months prior to the date the increase is effective, or if coverage is continued in a reduced paid up status. (Your "issue age" is your age on your birthday closest to the effective date of the inflation increase).

If you are a resident of CT, DE or KS the provision varies slightly. Call John Hancock for more information.

[2] If your coverage went into effect prior to January 1, 2005, your coverage may vary based on the coverage amounts you originally enrolled in, and whether you increased coverage through the inflation adjustment feature of the plan as those adjustments are offered every three (3) years; (See Inflation Adjustment Feature) or if you increased or decreased your coverage level.

[3] The total benefits payable for all informal care received in any calendar year is 21 times the Informal Care DMB.

Optional Reduced Paid-Up Coverage

If you elect this optional benefit when you apply, you can stop making premium payments after paying premiums for at least three years and retain a reduced level of coverage. If you exercise this benefit, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of 30 times the nursing home DMB or the sum of premiums paid in.

Of course, you may choose to continue paying your premiums and maintain your full benefit coverage. (New Mexico residents will have this benefit included in their coverage. It is not an option.)

Benefit Limits

The following Plan limits apply:

- The Daily Maximum Benefit amount for each covered service is determined by the option you select.
- There is a calendar year maximum for informal care services equal to 21 times 25% of the DMB of the option you select. For example, if you select Option 2, under enhanced coverage, the calendar year maximum for informal care services is $892.50 (25% of $170 times 21).
- The Lifetime Maximum Benefit is the total amount that the Plan may pay for long-term care expenses while you are insured. The Lifetime Maximum Benefit is calculated by multiplying your Nursing Home Daily Maximum Benefit by 1,825 (the number of days in five years) for enhanced coverage, or 730 (the number of days in two years) for comprehensive coverage. If you select Option 2 under enhanced coverage (with a $170 Nursing Home DMB), your Lifetime Maximum Benefit is $310,250. This amount provides you with at least five years of continuous coverage in a nursing home at $170 a day.

Only the actual amounts paid in benefits apply toward your Lifetime Maximum Benefit. For example, if you select Option 2 with a $170 DMB, and you enter a nursing home that costs $90 a day, only $90 is applied to your Lifetime Maximum Benefit for each day you are in the nursing home for which a benefit is paid. The remaining $80 stays in the Lifetime Maximum for future use.

Once the Lifetime Maximum Benefit is reached, you no longer are eligible for benefits and your coverage ends.

Qualifying for Benefit Payment

To qualify for benefits, you must meet two requirements:

- Be certified as dependent in at least two of the six Significant Activities of Daily Living or as cognitively impaired due to a covered condition, and
- Complete a 60-day Qualification Period. This period ensures that the care you need is Long-Term in nature.

You do not need to be hospitalized or confined in a nursing home to qualify for benefits.

Significant Activities of Daily Living

There are six Significant Activities of Daily Living (SADLs) 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).

You're dependent in an SADL if you need substantial assistance from another person to perform an SADL due to a loss of functional capacity and you are expected to continue to need this assistance for at least 90 days.

The case manager considers your cognitive and physical ability to perform these activities independently and appropriately without supervision or help from another person. For example, if you can't bathe or eat without substantial assistance from another person and that assistance is expected to continue for at least 90 days, you will be certified as dependent in these activities.

Cognitively Impaired

You are Cognitively Impaired if you have a deterioration or loss of intellectual capacity due to an organic brain disorder that requires you to need substantial supervision for the protection of yourself or others. Alzheimer's disease is an example of an organic brain disorder.

Qualification Period

The Qualification Period is the period of time you must wait from the date you are certified for benefits until the date benefits are payable for covered charges you incur. The Qualification Period is 60 days. You must remain certified 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 certified.

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, 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 SADL 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 SADL 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 SADL 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.

Should you die at or before age 65 while insured, the Plan will pay to your estate 100 percent of the premiums paid to date, minus any benefits paid or payable under the Policy. The percentage of premium returnable is reduced by 20 percent per year beginning at age 66, becoming zero at age 70. There is no return of premium if coverage is in paid up status under the reduced paid up benefit. The return of premium benefit is not available to residents of Arkansas and Washington.

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 conversion policy issued by John Hancock. If Dow discontinues the Plan, you may continue your coverage under a conversion policy issued by John Hancock.

The Plan's Assets

On January 27, 2000, the John Hancock Mutual Life Insurance Company changed its structure from a mutual company to a stock company, and changed its name to John Hancock Life Insurance Company, a subsidiary of John Hancock Financial Services, Inc. As a result, the Company, as the policyholder of the Master Group Policy, received shares of stock of John Hancock Financial Services, Inc. as compensation under John Hancock's demutualization plan. On April 25, 2000, the Company transferred the stock to The Dow Chemical Company Employees' Welfare Benefit Trust ("Welben") on behalf of the Plan. In May, 2000, the Plan Administrator and Welben transferred all of the stock to the Plan Participants who were holders of record of Long-Term care insurance certificates during the entire period beginning August 31, 1999 through December 31, 1999 ("Eligible Stock Participant"). Pursuant to the Plan Sponsor's amendments of the Plan Document and Summary Plan Description, each dated May 16, 2000, the stock was allocated in accordance with an allocation formula. Only whole shares of stock were distributed to Eligible Stock Participants. Partial shares of stock attributable to an Eligible Stock Participant were combined with partial shares of stock of other Eligible Stock Participants. The Plan Administrator was given the discretion to determine how to round partial shares in order to distribute whole shares to the Eligible Stock Participants. The shares were allocated in accordance with the following General Allocation Formula, which formula was adjusted at the Plan Administrator's discretion in order to adjust for the rounding of partial shares.

GENERAL ALLOCATION FORMULA:

134,668 X A% = B = Stock allocated to Eligible Stock Participant

A% = Amount of premium paid for the individual Eligible Stock Participant's Long-Term care coverage divided by the total premium paid for all Eligible Stock Participants for Long-Term care coverage since the effective date of the Plan.

With respect to plan assets that are not shares of stock resulting from the demutualization of John Hancock Mutual Insurance Company, the assets of the Plan may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as well as to pay for any reasonable 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.

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 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 Benfeits 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.

Amendment, Modification, or Termination of Plan.

The Dow Chemical Company reserves the right to amend, modify or terminated 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. It the Dow Chemical Company terminates the Program, the assets of the Program, if any, shall not be used by the 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 Program 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 (Applicable to those enrolled prior to July 1, 2007)*. The SPD and the insurance policies 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 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 Program, including its underlying plans, at any time at its sole discretion. The procedures for amending the Program are contained in the Plan Document for the Long-Term Care 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.

ERISA INFORMATION
LONG-TERM CARE INSURANCE PLAN
(Applicable to those enrolled prior to July 1, 2007)

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:	27182-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 for benefits. 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, the 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 SADLs 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 SADL 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 SADL 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 and incurring at least 30 days of qualified expenses for other than informal care, 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 SADL dependency or determines that you are not cognitively impaired, the case manager will notify you in writing. The letter will explain why the Claims were 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).