Summary Plan Description ("SPD") for:

Rohm and Haas Company Health and Welfare Plan's Disability Program's (ROH ERISA Plan #551):

LONG TERM DISABILITY PROGRAM (applicable to closed population of Non-Bargained Employees Whose Disability Began Before January 1, 2010)

Amended and Restated
Effective January 1, 2013 and thereafter until superseded

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

Copies of this SPD can be found on the Dow Friends website or by requesting a copy from the Retiree Service Center, Employee Development Center, Midland, MI 48674, telephone 877-623-8079 or 989-638-8757. Summaries of material modifications may also be published from time to time.

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Section 1. Overview

This document, including its appendices, is the Summary Plan Description ("SPD") for the Rohm and Haas Disability Program's Long Term Disability Program provided under the Rohm and Haas Company Health and Welfare Plan (ERISA Plan #551) that is applicable to a closed group of non-bargained Employees whose Disability occurred before January 1, 2010 (the "Plan").

The Plan is a group disability income protection plan to provide protection for you and your family in the event of a lengthy disability. The Plan is sponsored by The Dow Chemical Company (the "Company").

If your Disability began on or after January 1, 2010, you are not eligible for the Plan, but you may contact the Dow Retiree Service Center to see whether you qualify under The Dow Chemical Company Long Term Disability Plan.

This SPD is a summary of the Plan Document. If there is an inconsistency between the SPD and the Plan Document, the Plan Document will govern. The Plan Document is available upon request from the Plan Administrator identified in *Section 20. ERISA Information*.

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

The SPD and the Plan do not constitute a contract of employment. Words that are capitalized are either defined in the *Definitions Appendix* to this SPD or in the Plan Document.

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

Section 2. Eligibility and Participation

A. Eligible Employees

The Plan applies only to eligible non-bargained Employees of Rohm and Haas Company or a Participating Employer whose qualifying Disability or Partial Disability occurred before January 1, 2010. You are eligible for coverage under the Plan if:

- You were a non-bargained Employee of Rohm and Haas Company or a Participating Employer whose regular work schedule was greater than 20 hours per week;
- You were in Active Employment before January 1, 2010; and
- Your Disability began before January 1, 2010.

Please note that Morton International, Inc. ceased to be a Participating Employer effective October 1, 2009. Please also note that the term "Associated Company" (as defined in the contract with Liberty, the Plan's claims administrator) is intended to have the same meaning as "Participating Employer" (as defined in the Plan Document).

The definition of "Employee" does not include temporary employees (regardless of whether you are eligible for any other benefit), seasonal employees, leased employees, independent contractors, any person designated by Rohm and Haas Company or a Participating Employer at the time of hire as not

eligible to participate in the Plan, even if such ineligible person is subsequently determined to be an "employee" by any government or judicial authority, or any member of a group or class not eligible for benefits as designated by the Employer.

B. Enrollment and Cost of Coverage

You did not need to enroll in the Plan; eligible Employees were automatically enrolled, and the Company paid the cost of the LTD income protection coverage.

C. Family and Medical Leave

If you were a Covered Person and your qualifying Disability occurred prior to January 1, 2010, you were permitted to continue coverage under this Plan if you were on an approved family or medical leave of absence for up to 12 weeks following the date coverage would have otherwise terminated, subject to the following:

- The authorized leave must have been in writing.
- The Covered Person's benefit level, or the amount of earnings upon which the Covered Person's benefit may be based, is that in effect on the date before such leave began.
- Continuation of coverage ceases immediately at the earliest of the following dates: (1) the Covered Person returns to work; (2) the Plan terminates; (3) the Covered Person's job is eliminated; (4) the Covered Person's employment terminates.

Section 3. Long Term Disability Benefits

A. Requirements to Receive LTD Payments

To receive LTD payments, none of the exclusions listed in Sections 3.I, 3.J, 3.K or 9 of this SPD, below, may apply and you must:

- Meet the eligibility requirements (see Section 2. Eligibility and Participation);
- Have been Disabled before January 1, 2010 (see *Definitions Appendix A*); and
- Have completed the Elimination Period (see *Definitions Appendix A*).

B. Amount of LTD Benefits

The amount of your LTD benefit is equal to 66.7% of your Basic Monthly Earnings (subject to a maximum benefit of $20,000 per month), and then *reduced by Other Income Benefits and Other Income Earnings* as described in subsection C, below.

Prorated Benefits

For any period for which a Plan benefit is payable that does not extend through a full month, the benefit is paid on a prorated basis. The rate will be 1/30th for each day for such period of Disability.

C. LTD Benefits Reduced by Other Income Benefits and Other Income Earnings

Your LTD benefit is reduced by Other Income Benefits and Other Income Earnings.

Other Income Benefits means:

1. The amount for which the Covered Person is eligible under:

    - Workers' or Workmen's Compensation Laws;
    - Occupational Disease Law;
    - Title 46, United States Code Section 688 (The Jones Act);
    - any work loss provision in mandatory "No-Fault" auto coverage;
    - Railroad Retirement Act;
    - any governmental compulsory benefit act or law; or
    - any other act or law of like intent.

2. The amount of any Disability benefits which the Covered Person is eligible to receive under:

    - any group short term disability or other long term disability plan of the Plan Sponsor;
    - any governmental retirement system as a result of his employment with the Employer; or
    - any individual short term disability or long term disability plan where the premium is or was wholly or partially paid by the Plan Sponsor. However, the Plan will only reduce the Monthly Benefit if the Covered Person's Monthly Benefit under this Plan, plus any benefits that the Covered Person is eligible to receive under such individual coverage plan exceed 100% of the Covered Person's Basic Monthly Earnings. If this sum exceeds 100% of Basic Monthly Earnings, the Covered Person's Monthly Benefit under this plan is reduced by such excess amount.

3. The amount of Disability Benefits the Covered Person receives under a Retirement Plan, such as the Rohm and Haas Company Retirement Plan.

4. The amount of Disability and/or Retirement Benefits the Covered Person receives or is eligible to receive under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.

5. Any amount the Covered Person receives from any unemployment benefits.

Other Income Earnings means:

1. Any amount the Covered Person receives from any formal or informal sick leave or salary continuation plan(s) or payroll practice; and

2. The amount of earnings the Covered Person earns or receives from any form of employment including severance.

Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which the Plan pays a benefit. The sum of Other Income Benefits and Other Income Earnings are

deducted from benefits payable under the Plan. The Plan reduces the Covered Person's Disability or Partial Disability benefits by the amount of Other Income Benefits that the Plan estimates are payable to the Covered Person and his dependents. However, the Covered Person's Disability benefit is not be reduced by the estimated amount of Other Income Benefits if the Covered Person:

- provides satisfactory proof of application for Other Income Benefits;
- signs a reimbursement agreement under which, in part, the Covered Person agrees to repay the Plan for any overpayment resulting from the award or receipt of Other Income Benefits;
- if applicable, provides satisfactory proof that all appeals for Other Income Benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and
- if applicable, submits satisfactory proof that Other Income Benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

The Plan will not estimate or reduce for any benefits under the Plan Sponsor's pension or retirement benefit plan, until the Covered Person actually receives them.

In the event that the Plan overestimates the amount payable to the Covered Person from any plans referred to in the Other Income Benefits and Other Income Earnings provision of this Plan, the Plan will reimburse the Covered Person for such amount upon receipt of written proof of the amount of Other Income Benefits awarded (whether by compromise, settlement, award or judgment) or denied (after appeal through the highest administrative level).

The Plan Administrator may help a Covered Person in applying for Social Security Disability Income Benefits. In order to be eligible for assistance the Covered Person must be receiving a Monthly Benefit from the Plan. Such assistance will be provided only if the Plan determines that assistance would be beneficial to the Plan.

Lump Sum Payments

Your LTD Plan benefit also is reduced by Other Income Benefits from a compromise, settlement, award or judgment which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:

- loss of past or future wages;
- impaired earnings capacity;
- lessened ability to compete in the open labor market;
- any degree of permanent impairment; and
- any degree of loss of bodily function or capacity.

For lump sum payments, your LTD benefit reduction is prorated on a monthly basis as follows:

- Over the period of time such benefits would have been paid if not in a lump sum; or

- If such period of time cannot be determined, the lesser of (1) the remainder of the Maximum Benefit Period, or (2) 5 years.

Cost of Living Freeze

After the first deduction for each of the Other Income Benefits, the Monthly Benefit is not further reduced due to any cost of living increases payable under the Other Income Benefits and Other Income Earnings provision of this Plan. This provision does not apply to increases received from any form of employment.

D. Maximum Benefit Period:

A Covered Person's LTD payments may not exceed the maximum benefit period described below. The LTD payments may terminate prior to the maximum benefit period if any of the reasons for discontinuance of the LTD benefits described in Section 3.I of this SPD, below, apply.

Age at Disability	**Maximum Benefit Period**
Less than age 60	To the greater of SSNRA* or age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

*SSNRA refers to the Social Security Normal Retirement Age, as determined by the 1983 amendment to the Social Security Act and any subsequent amendments thereto, as follows:

Year of Birth	**SSNRA**
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and after	67

E. Proof of Disability and Continuing Proof of Disability

If you filed a claim for disability payments, you must have provided proof that you had a qualifying Disability or Partial Disability as defined under the Plan. This proof must have been provided no later than 30 days after the end of the 180-day Elimination Period, at your own expense.

Once you are being paid monthly LTD Plan benefits, the Claims Administrator has the right to request proof of a qualifying disability as often as it reasonably chooses. In general, you must provide proof, at your own expense, of the qualifying disability within 30 days of the Claims Administrator's request for such proof.

LTD Plan benefits are not payable if you failed to provide satisfactory proof of a qualifying disability when you filed an LTD claim, or later when the Claims Administrator asks for it; nor are Plan benefits payable for any period of time during which you are not under the care of a Physician for the disability.

A statement from a Physician without objective evidence may not be sufficient proof of a qualifying disability. It is strongly recommended that you work with your doctor to make sure that the Claims Administrator is presented with all available and relevant evidence (e.g., medical examination, tests) to support your claim that you meet the definition of a qualifying disability. For example, a current medical examination and tests should be obtained near in time to the date you file your claim to show the current status of your disability. Medical examinations and tests by your treating physician are not paid for by the Plan. If the Claims Administrator informs you that you do not have sufficient proof of disability, you should discuss the situation with your physician as soon as possible to make sure that the Claims Administrator is provided all the information that it needs to make a decision on your claim.

A decision by your employer that you cannot perform the essential functions of your job with or without reasonable accommodation is independent of the Claims Administrator's decision as to whether you meet the definition of a qualifying disability, and is based on different criteria and requirements of proof than the qualifying disability determination by the Claims Administrator.

In determining whether the Covered Person is Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Disabled due to Injury or Sickness and requires the Regular Attendance of a Physician, the Plan will pay the Covered Person a Monthly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person provides the Claims Administrator proof of:

- Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

For purposes of determining Disability, the Injury or Sickness must occur and Disability must begin while the Employee is covered under the Plan.

F. Working While Disabled: Partial Disability

If you become Partially Disabled while you are covered under the Plan, you may qualify for partial disability benefits as long as you are able to prove your continued Disability and as long as work that meets your accommodation needs (as determined by a medical professional) is available to you.

Proof of Partial Disability must be given upon the Claims Administrator's request and at the Covered Person's expense. In determining whether the Covered Person is Partially Disabled, the Claims Administrator does not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification, including non-renewal or non-recertification due to the commission of a misdemeanor. The Claims Administrator considers loss of a professional or occupational license or certification if non-renewal or non-recertification is due to the existence of a medical condition.

When the Claims Administrator receives Proof that a Covered Person is Partially Disabled and has experienced a loss of earnings due to Injury or Sickness and requires the Regular Attendance of a Physician, he may be eligible to receive a Monthly Benefit, subject to any other provisions of the Plan. To be eligible to receive Partial Disability benefits, the Covered Person may be employed in his Own Occupation or another occupation, must satisfy the Elimination Period and must be earning between 20% and 80% of his Basic Monthly Earnings.

A Monthly Benefit will be paid for the period of Partial Disability if the Covered Person gives to the Claims Administrator Proof of continued:

- Partial Disability;
- Regular Attendance of a Physician; and
- Appropriate Available Treatment.

The Proof must be given upon the Claims Administrator's request and at the Covered Person's expense.

For purposes of determining Partial Disability, the Injury must have occurred and the Partial Disability must have begun while you were covered under the Plan.

G. Partial Disability Benefit Amount

For the first 12 months, the work incentive benefit will be an amount equal to the Covered Person's Basic Monthly Earnings multiplied by the benefit percentage shown in the Plan specifications, without any reductions from earnings. The work incentive benefit will be reduced only if the Monthly Benefit payable plus any earnings exceed 100% of the Covered Person's Basic Monthly Earnings. If the combined total is more, the Monthly Benefit will be reduced by the excess amount so that the Monthly Benefit plus the Covered Person's earnings does not exceed 100% of his Basic Monthly Earnings.

Thereafter, the Monthly Benefit will be calculated as follows:

- First, subtract from the Covered Person's Basic Monthly Earnings the Covered Person's earnings received while he is Partially Disabled. (This figure represents the amount of lost earnings.);
- Second, multiply the amount of lost earnings by 75%; and

- Third, deduct Other Income Benefits (shown in the Other Income Benefits and Other Income Earnings provision of this plan) from the amount calculated in the second step.

The Monthly Benefit payable will not be less than the Minimum Monthly Benefit shown in the Schedule of Benefits. However, if an overpayment is due to the Plan, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

H. Three Month Survivor Benefit

The Plan will pay a lump sum benefit to the Eligible Survivor when Proof is received that a Covered Person died after his Disability had continued for 180 or more consecutive days and while he was receiving a Monthly Benefit. The lump sum benefit will be an amount equal to three times the Covered Person's Last Monthly Benefit.

If the survivor benefit is payable to the Covered Person's children, payment is made in equal shares to the children, including step-children and legally adopted children. However, if any of said children are minors or incapacitated, payment is made on the children's behalf to the court appointed guardian of the property. This payment is valid and effective against all claims by others representing or claiming to represent the children.

If there is no Eligible Survivor, the benefit is payable to the estate.

If an overpayment is due to the Plan at the time of a Covered Person's death, the benefit payable under this provision is applied toward satisfying the overpayment.

I. Discontinuation of the Long Term Disability Benefit

The Monthly Benefit ceases on the earliest of the date on which the Covered Person:

1. Fails to provide Proof of continued Disability or Partial Disability and Regular Attendance of a Physician;

2. Fails to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;

3. Refuses to be examined or evaluated at reasonable intervals;

4. Refuses to receive Appropriate Available Treatment;

5. Refuses a job with the Employer where workplace modifications or accommodations were made to allow the Covered Person to perform the Material and Substantial Duties of the job;

6. Is able to work in their Own Occupation on a part-time basis, but chooses not to;

7. Has current Partial Disability earnings that exceed 80% of his Basic Monthly Earnings. (For these purposes, the Plan averages earnings over three consecutive months rather than immediately terminating his benefit once 80% of Basic Monthly Earnings has been exceeded.);

8. Is no longer Disabled or Partially Disabled according to this Plan;

9. Reaches the end of the Maximum Benefit Period;

10. Dies;

11. Retires; or

12. Quits employment.

J. What LTD Does Not Cover

LTD benefits under the Plan are not paid unless you were a Covered Person, satisfied the Elimination Period requirement, met the definition of Disability or Partial Disability before January 1, 2010, and are under the care of a Physician. No benefits are paid during periods of incarceration or imprisonment. In addition, no benefits are payable from the Plan for Disabilities or Partial Disabilities due to:

- Any war (declared or undeclared) or act of war;
- Intentionally inflicted injuries while sane or insane;
- Active participation in a riot;
- A pre-existing condition (see Subsection K. Pre-Existing Condition Exclusion);
- Your committing, or attempt to commit, a felony or misdemeanor;
- Cosmetic surgery, unless in connection with an injury or illness sustained while covered under the LTD Plan; or
- A gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

K. Pre-Existing Condition Exclusion

The Plan does not cover any Disability or Partial Disability which:

- is caused or contributed to by, or results from, a Pre-Existing Condition; and
- begins in the first 12 months immediately after the Covered Person's effective date of coverage.

Pre-Existing Condition means a condition resulting from an Injury or Sickness for which the Covered Person is diagnosed or received Treatment within three months prior to the Covered Person's effective date of coverage.

L. Mental Illness and/or Substance Abuse Limitation

The benefit for disability due to Mental Illness and/or Substance Abuse will not exceed a combined period of 24 months of monthly benefit payments while you are covered under the Plan; however, if you are in a Hospital or Institution for Mental Illness and/or Substance Abuse at the end of the combined period of 24 months, the monthly benefit will continue to be paid during the period of your confinement.

If you are not confined in a Hospital or Institution for Mental Illness and/or Substance Abuse, but are fully participating in an extended treatment plan for the condition that caused your Disability, the monthly benefit will be payable to you for up to a combined period of 36 months.

M. To Whom LTD Payments are Paid

In general, the Plan benefit is payable only to the Covered Person. However, if a benefit is payable to a Covered Person's estate or to a Covered Person who is not competent, the Plan has the right to pay up to $2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Section 4. Ancillary Benefits

If you are receiving benefit payments under the Plan, you may be eligible to continue coverage under certain employee benefit plans ("ancillary benefit plans"). Please note that these ancillary benefits are not provided under the Plan. Instead, the terms of the ancillary benefit plans may extend eligibility to you because of your status under the Plan.

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

Benefit Coverage	What Happens to Coverage While on an Approved Disability
Employee Purchased Life Insurance	You are eligible for coverage while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work, and you must make timely premium contributions in order to continue coverage.
Reimbursement Accounts (Health Care Reimbursement Account (HCRA) and Dependent Day Care Reimbursement Account(DCRA))	You may not continue to make contributions to DCRA or HCRA while you are receiving LTD payments.
Medical and Dental Insurance	In general, you are eligible to continue coverage for yourself and your eligible dependents under The Dow Chemical Company Medical Care Program, The Dow Chemical Company Dental Assistance Program and/or The Dow Chemical Company Insured Health Program, while you are receiving Plan benefit payments, as long as you continue to make any required contributions. Refer to the summary plan descriptions for those programs for more information. You may qualify for Social Security disability benefits, or you may be eligible for Medicare. Ask your local Social Security office for details.
Accidental Death and Dismemberment Insurance (formerly PAI)	You are eligible for accidental, death and dismemberment insurance while you are receiving Plan benefit payments. However, you may not enroll or increase coverage until you return to work and you must make timely premium contributions.
Company-Paid Life Insurance	You are eligible for company-paid life insurance coverage while you are receiving Plan benefit payments.
Service Credit	You do not continue to accumulate benefit service while you are receiving Plan benefit payments.

Benefit Coverage	What Happens to Coverage While on an Approved Disability
Travel Accident Insurance and Occupational Accident Insurance	Travel accident and occupational accident insurance coverage (such as through Dow's BTA/OAI Plan) stops when you begin receiving Plan benefit payments.
Vacation Time	Vacation time cannot be taken while you are receiving Plan benefit payments.
Holidays	A Holiday is considered a regular work day when calculating disability benefits.
401(k) Plan	In general, you may leave your account in the 401(k) plan until April 1st after you reach age 70½. If you have a loan(s), you must continue to repay the loan. If no loan payments are made and you do not return to work within one year, your loan defaults.
Pension Plan	In general, you continue to earn service credit under the Rohm and Haas Company Retirement Plan while you are receiving Plan benefit payments.

Section 5. Fraud Against the Plan

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

Section 6. Subrogation

As used in this Section 6 these terms have the following meaning:

- "Covered Person" means a participant in the Plan, the parents and legal guardians of a participant who is a minor, and the heirs, administrators, and executors of a participant's estate.

- "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition, without regard to whether such party caused the illness, injury, or condition. The term "Responsible Party" includes the liability insurer of such party, any Insurance Coverage, and any employer, agent, or principal of such party.

- "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

The Plan's Entitlement to Reimbursement

Subrogation. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to the

Covered Person's injury, illness or condition to the full extent of benefit provided or to be provided by the Plan.

Reimbursement. If a Covered Person receives any payment from a Responsible Party as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition (including attorneys' fees and other costs incurred in enforcing the Plan's rights), up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust. By accepting benefits from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan, and the Plan may pursue equitable remedies to recover the monies or withhold future benefits until reimbursement is made.

Lien Rights. The Plan will automatically have a lien to the extent of benefits paid by the Plan for which the Responsible Party is alleged to be liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; the Responsible Party, the Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim. By accepting benefits from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Third Parties and are to be paid to the Plan before any other claim for the Covered Person's damages (including before attorneys' fees and other expenses). The Plan is entitled to full reimbursement on a first-dollar basis from any Responsible Party Payments, ***even if such payment to the Plan will result in a recovery to the Covered Person that is insufficient to make him or her whole*** (*i.e.*, the "make whole" doctrine will not apply).

Applicability to All Settlements and Judgments. The Plan is entitled to full recovery regardless of whether any liability for payment is admitted by the Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only (*i.e.*, the "common fund" doctrine will not apply).

Plan Not Required to Pay Court Costs or Attorneys' Fees. The Plan is not required to participate in or pay court costs or attorneys' fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim. Should it be necessary for the Plan to institute legal action against a Covered Person (or assignee) for failure to reimburse the Plan in full, or for failure to honor the Plan's equitable interest in the amount recovered from a Responsible Party, the Covered Person shall be liable for all costs of collection, including reasonable attorneys' fees.

Your Responsibilities

The Covered Person is required to fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Claims Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness

or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. The rights described in this Section 6 are assigned to the Plan without the need for a separate written agreement. However, the Covered Person is required to execute and deliver to the Plan an assignment and other instruments that may be used to facilitate securing the rights of the Plan. The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the Plan's provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Plan may withhold future benefits or terminate the Participant *and* the Covered Person from the Plan if the Covered Person does not fully cooperate with the Plan's efforts to recover the benefits paid by the Plan. In addition, if the Participant or the Covered Person is terminated from eligibility under ***any*** benefit plan sponsored by The Dow Chemical Company or any of its subsidiaries or affiliates because of failure to reimburse that benefit plan, the Plan Administrator may determine that the Participant and/or the Covered Person are disqualified from eligibility for coverage under the Plan.

The Covered Person acknowledges by accepting benefits from the Plan that the Plan has the right to conduct an investigation regarding the injury, illness or condition in order to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Covered Person's obligation to reimburse the Plan is limited to the amount of benefits the Plan has paid, or will pay, to the Covered Person as a result of the injury, illness, or condition sustained. However, if the Plan must institute a legal action because a Covered Person fails to reimburse the Plan in full or to honor the Plan's equitable interest in any recovery, the Covered person will be liable for all costs of collection, including reasonable attorneys' fees.

If the Plan has overpaid you any overpayments made to you may be offset by the Plan in future payments or claims.

Jurisdiction

For purposes of this Section 6, by accepting benefits from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Section 7. Overpayments

Whenever a disability payment is made under the Plan, the Claims Administrator has the right to recover any overpayments (including Survivor Benefits), whether due to fraud, an error in processing a claim, or your receipt of other sources of income. You will be required to reimburse the Claims Administrator for the full amount of the overpayment. The method by which the repayment is made will be determined by the Claims Administrator (this repayment will never exceed the benefit amount paid to you by the Plan). Required reimbursements must be satisfied before Plan benefits may continue.

Section 8. Workers Compensation

This Plan and the Plan coverage provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

Section 9. Termination of a Covered Person's Coverage

A Covered Person ceases to be covered under the Plan on the earliest of the following dates:

- the date the Plan terminates, but without prejudice to any claim originating prior to the time of termination;
- the date the Covered Person is no longer an Employee of Rohm and Haas Company or of a Participating Employer;
- the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except the coverage will be continued for an Employee absent due to Disability during the Elimination Period; or
- the date the Covered Person ceases active work due to a labor dispute, including any strike, work slowdown, or lockout.

Section 10. No Assignment

No assignment of any present or future right or benefit under this Plan is allowed.

Section 11. Litigation

If you wish to file a lawsuit against the Plan (1) to recover benefits you believe are due to you under the terms of the Plan or any law; (2) to clarify your right to future benefits under the Plan; (3) to enforce your rights under the Plan; or (4) to seek a remedy, ruling or judgment of any kind against the Plan or the Plan fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Plan, then under the terms of the Plan you must file the suit within the Applicable Limitations Period or your suit will be time-barred.

The Applicable Limitations Period is the period ending 120 days after:

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the Plan or to clarify your right to future benefits under the terms of the Plan, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Plan first repudiated its alleged obligation to provide such benefits;
2. in the case of a claim or action to enforce an alleged right under the Plan (other than a claim for benefits), the date the Plan first denied your request to exercise such right; or
3. in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

A claim for benefits or an appeal of a complete or partial denial of a claim, as described in the claims and appeals sections, generally falls under (1) above. Please note, however, that if you have a timely claim pending before the Initial Claims Reviewer or a timely appeal pending before the Appeals Administrator

when the Applicable Limitations Period would otherwise expire, the Applicable Limitations Period will be extended to the date that is 60 calendar days after the Appeals Administrator renders its final decision.

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

Section 12. Class Action Lawsuits

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

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

This forum selection provision is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations. This provision does not waive the requirement to exhaust administrative remedies before initiating litigation.

Section 13. Legal and Administrative Information

This section provides an explanation of your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and important facts about the administration of the Plan.

Your Legal Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report, the Plan Document, and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies.

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

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

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

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

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

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

Section 14. Plan Administrator's Discretion

The Plan Administrator is each of the Vice President, Human Resources Center of Expertise; the Global Benefits Director; the Associate Director of North America Benefits; the North America Health and Welfare Plans Leader; and such other person, group of persons, or entity which may be designated by the Plan Sponsor in accordance with the Plan Document as a named fiduciary with respect to administration of the Plan. Except for the duties reserved for the Claims Administrator, the Plan Administrator and any other person or committee designated by the Company to carry out these functions have the sole and absolute discretion to interpret the Plan Document, this SPD, and other relevant Plan documents, make findings of fact, and adopt rules and procedures applicable to matters within their jurisdiction. Their interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if their interpretations or determinations are challenged in court, they shall not be overturned unless proven to be arbitrary and capricious. See "*Claims Procedures Appendix*" for information about the Claims Administrator's discretion.

Section 15. Welfare Benefits

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

Section 16. Amendment, Modification, or Termination of Plan

The 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.

Section 17. Disposition of Plan Assets if the Plan is Terminated

If The Dow Chemical Company terminates the Plan, the assets of the Plan, if any, shall not be used by The Dow Chemical Company, but may be used to:

- provide benefits for Participants in accordance with the Plan;
- pay third parties to provide such benefits;
- pay expenses of the Plan and/or the Trust holding the Plan's assets; and/or
- provide cash for Participants, as long as the cash is not provided disproportionately to officers, shareholders, or highly compensated employees.

Section 18. Uncashed Checks

Uncashed checks for the payment of benefits shall not escheat to the state, but shall remain in the Company's general assets. The Plan and Claims Administrators are entitled to rely on the last address provided to the Plan by the Participant and have no obligation to search for or ascertain a Participant's whereabouts. If the applicable Administrator determines that there are no extenuating circumstances, after one (1) year of the date of the check, the Plan's obligation to pay the benefit underlying the uncashed check is extinguished, and the payment of benefits will be forfeited.

Section 19. For More Information

If you have questions, contact the Retiree Service Center, Employee Development Center, Midland, Michigan 48674 or call 1-877-623-8079.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for The Rohm and Haas Company's Health and Welfare Plan's Disability Program's Long Term Disability Program, as applicable to certain non-bargained employees who become Disabled before January 1, 2010 (the "Plan"). However, this booklet is not all-inclusive and it is not intended to take the place of the Plan's legal documents.

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

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

Section 20. ERISA Information

The Rohm and Haas Company Health and Welfare Plan Disability Program's Long Term Disability Program (Applicable to Certain Non-Bargained Employees Who Became Disabled before January 1, 2010)

Plan Sponsor:	The Dow Chemical Company Employee Development Center Midland, MI 48674
Plan Administrator:	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, MI 48674 877-623-8079
Type of Plan:	Long-term disability benefit.
Type of Plan Administration:	Self-insured benefits, claims administered by Liberty.
Employer Identification Number:	38-1285128
Plan Number:	551
Liberty Group Number:	03-490950
Claims Administrators for Claims for Eligibility Determinations:	*Initial Claims Reviewer:* North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, MI 48674 Attention: Initial Claims Reviewer for the Rohm and Haas Long Term Disability Program - Certain Non-Bargained Employees *Appeals Administrator:* Associate Director of North America Benefits The Dow Chemical Company Employee Development Center Midland, MI 48674 Attention: Appeals Administrator for the Rohm and Haas Long Term Disability Program - Certain Non-Bargained Employees
Claims Administrator for Claims for Plan Benefits:	Liberty Group Benefits Disability Claims Liberty Life Assurance Company of Boston P.O. Box 7211 London, KY 40742-7211
To Serve Legal Process:	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:	Dow pays the entire cost of the Plan from its general assets.

APPENDIX A
DEFINITIONS

"**Active Employment**" means the Employee must be actively at work for the Employer on a full-time or part-time basis and paid regular earnings and perform such work either (1) at the Employer's usual place of business, or (2) at a location to which the Employer's business requires the Employee to travel.

An Employee will be considered actively at work if he was actually at work on the day immediately preceding a weekend (except where one or both of these days are scheduled work days); a holiday (except when the holiday is a scheduled work day); a paid vacation; any non-scheduled work day; an excused leave of absence (except medical leave for the Covered Person's own disabling condition, voluntary leave of absence in lieu of lay-off and lay-off); and an emergency leave of absence (except emergency medical leave for the Covered Person's own disabling condition).

"**Any Occupation**" means any occupation that the Covered Person is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

"**Appeals Administrator**" means, with respect to reviewing an adverse Claim for Benefits, Liberty, and, with respect to reviewing an adverse Claim for an Eligibility Determination, the Global Benefits Director and the Associate Director of North America Benefits for The Dow Chemical Company.

"**Appropriate Available Treatment**" means care or services which are:

- generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within the Covered Person's geographical region;
- provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
- in accordance with generally accepted medical standards of practice.

"**Basic Monthly Earnings**" means the Covered Person's monthly rate of earnings from the Employer in effect immediately prior to the date Disability or Partial Disability begins, up to a maximum of $29,985 per month. Such earnings will not include bonuses, commissions, overtime pay and extra compensation.

"**Claims Administrator**" means either the Initial Claims Reviewer or the Appeals Administrator, depending on the context of the sentence in which the term is used.

"**Covered Person**" means an Employee covered under this Plan.

"**Disability**" or "**Disabled**" means as follows:

- For persons other than pilots, co-pilots, and crewmembers of an aircraft, "Disability" or "Disabled" means:
    - during the Elimination Period and the next 24 months of Disability the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Own Occupation; and

- Thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

- With respect to Covered Persons employed as pilots, co-pilots and crewmembers of an aircraft, "Disability" or "Disabled" means as a result of Injury or Sickness the Covered Person is unable to perform the Material and Substantial Duties of Any Occupation.

"**Disability Benefits under a Retirement Plan**" means money which:

- is payable under a Retirement Plan due to Disability as defined in that plan; and

- does not reduce the amount of money which would have been paid as Retirement Benefits at the normal retirement age under the plan if the Disability had not occurred. (If the payment does cause such a reduction, it will be deemed a Retirement Benefit as defined in this Plan.)

"**Domestic Partner**" means an unmarried person of the same or opposite sex with whom the Covered Person shares a committed relationship, are jointly responsible for each other's welfare and financial obligations, at least 18 years of age and mentally competent to consent to a contract, not related by blood to a degree that could prohibit legal marriage in the state where they legally reside, maintain the same residence(s) and are not married to or legally separated from anyone else. A Domestic Partner certification must be completed and filed with the Plan Administrator before the partner can be designated as an Eligible Survivor.

"**Eligibility Date**" means the date an Employee becomes eligible for coverage under this Plan.

"**Eligible Survivor**" means the Covered Person's spouse or Domestic Partner, if living, otherwise the Covered Person's children under age 25.

"**Elimination Period**" means a period of consecutive days of Disability or Partial Disability for which no benefit is payable. The Elimination Period is the greater of either (1) the period the Covered Person receives Short Term Disability benefits, salary continuation, or pay from a payroll practice, or any combination thereof, or (2) 180 days.

If the Covered Person returns to work for any 30 or fewer days during the Elimination Period and cannot continue, the Plan Administrator will count only those days the Covered Person is Disabled or Partially Disabled to satisfy the Elimination Period.

"**Employer**" means Rohm and Haas Company and its Participating Employers. Please note that Morton International, Inc. ceased to be a Participating Employer effective October 1, 2009.

"**Extended Treatment Plan**" means continued care that is consistent with the American Psychiatric Association's standard principles of Treatment, and is in lieu of confinement in a Hospital or Institution. It must be approved in writing by a Physician.

"**Family and Medical Leave**" means a leave of absence for the birth, adoption or foster care of a child, or for the care of the Covered Person's child, spouse or parent or for the Covered Person's own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

"**Hospital**" or "**Institution**" means a facility licensed to provide Treatment for the condition causing the Covered Person's Disability.

"**Initial Claims Reviewer**" means, with respect to deciding Claims for Plan Benefits, Liberty, and, with respect to deciding a Claim for an Eligibility Determination, the North America Health and Welfare Plans Leader for The Dow Chemical Company.

"**Injury**" means bodily impairment resulting directly from an accident and independently of all other causes. For the purpose of determining benefits under this Plan:

- any Disability which begins more than 60 days after an Injury will be considered a Sickness; and
- any Injury which occurs before the Covered Person is covered under this Plan, but which accounts for a medical condition that arises while the Covered Person is covered under this Plan will be treated as a Sickness.

"**Last Monthly Benefit**" means the Monthly Benefit payable to the Covered Person prior to their death without any reduction for earnings received from employment.

"**Liberty**" means Liberty Life Assurance Company of Boston, 100 Liberty Way, Dover, New Hampshire 03820.

"**Material and Substantial Duties**" means responsibilities that are normally required to perform the Covered Person's Own Occupation, or any other occupation, and cannot be reasonably eliminated or modified.

"**Mental Illness**" means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, the Sponsor will use the replacement chosen or published by the American Psychiatric Association.

"**Monthly Benefit**" means the monthly amount payable by the Plan Sponsor to the Disabled or Partially Disabled Covered Person.

"**Own Occupation**" means the Covered Person's occupation that he was performing when his Disability or Partial Disability began. For the purposes of determining Disability under this Plan, the Plan will consider the Covered Person's occupation as it is normally performed in the national economy.

"**Partial Disability**" or "**Partially Disabled**" means the Covered Person, as a result of Injury or Sickness, is able to:

- perform one or more, but not all, of the Material and Substantial Duties of his Own Occupation or Any Occupation on an Active Employment or a part-time basis; or
- perform all of the Material and Substantial Duties of his Own Occupation or Any Occupation on a part-time basis; and
- earn between 20% and 80% of his Basic Monthly Earnings.

"**Physician**" means a person who:

- is licensed to practice medicine and is practicing within the terms of his license; or

- is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the Treatment is received and is practicing within the terms of his license.

Physician does not include a Covered Person, any family member or domestic partner.

"**Plan**" means the Rohm and Haas Health and Welfare Plan's Disability Program's Long Term Disability Program that is applicable to a closed group of non-bargained Employees whose Disability occurred before January 1, 2010.

"**Plan Administrator**" means each of the Vice President, HR Center of Expertise; Global Benefits Director; Associate Director of North America Benefits; and North America Health and Welfare Plans Leader; and such other person, group of persons or entity which may be designated by The Dow Chemical Company in accordance with the Plan Document.

"**Plan Document**" means the plan document for the Rohm and Haas Company Health and Welfare Plan, ERISA Plan #551. The summary plan descriptions for the plans offered under the Rohm and Haas Company Health and Welfare Plan are integral parts of the Plan Document..

"**Plan Sponsor**" means The Dow Chemical Company.

"**Proof**" means the evidence in support of a claim for benefits and includes, but is not limited to, the following:

- a claim form completed and signed (or otherwise formally submitted) by the Covered Person claiming benefits;

- an attending Physician's statement completed and signed (or otherwise formally submitted) by the Covered Person's attending Physician; and

- the provision by the attending Physician of standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.

Proof must be submitted in a form or format satisfactory to the Plan Administrator and Liberty.

"**Regular Attendance**" means the Covered Person's personal visits to a Physician which are medically necessary according to generally accepted medical standards to effectively manage and treat the Covered Person's Disability or Partial Disability.

"**Retirement Benefit under a Retirement Plan**" means money which:

- is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;

- does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received); and

- is payable upon:

    - early or normal retirement; or

- Disability, if the payment does reduce the amount of money which would have been paid under the plan at the normal retirement age.

"**Retirement Plan**" means a plan, such as the Rohm and Haas Company Retirement Plan, which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, informal salary continuation plan, registered retirement savings plan, stock ownership plan, 401(K) or a non-qualified plan of deferred compensation.

"**Sickness**" means illness, disease, pregnancy or complications of pregnancy.

"**SPD**" means this Summary Plan Description. The Summary Plan Description is an integral part of the Plan Document.

"**Substance Abuse**" means alcohol and/or drug abuse, addiction, or dependency.

"**Treatment**" means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the Covered Person chooses to take them or not, and taking drugs and/or medicines.

APPENDIX B
CLAIMS PROCEDURES FOR LONG TERM DISABILITY

You Must File a Claim in Accordance with these Claims Procedures

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

- A Claim for Plan Benefits is a request for Plan benefits.
- A Claim for an Eligibility Determination is a request for a determination as to whether a claimant is eligible to enroll in the Plan.

You must follow the claims procedures for either a Claim for Plan Benefits or a Claim for an Eligibility Determination, whichever applies to your situation. See the section entitled *CLAIMS FOR PLAN BENEFITS* for the procedures regarding Claims for Plan Benefits. See the section entitled *CLAIMS FOR ELIGIBILITY DETERMINATIONS* for the procedures regarding Claims for Eligibility Determinations.

Who Will Decide Whether to Approve or Deny My Claim?

The Plan has more than one Claims Administrator. Each of the Claims Administrators is a named fiduciary of the Plan with respect to the respective types of claims that they process. The initial determination for a Claim for an Eligibility Determination is made by the Initial Claims Reviewer. If you appeal, the appellate decision is made by the Appeals Administrator.

Claims for Eligibility Determinations. The Initial Claims Reviewer for Claims for Eligibility Determinations is the North America Health and Welfare Plans Leader. The Global Benefits Director and the Associate Director of North America Benefits are the Appeals Administrators for appeals of denied Claims for Eligibility Determinations.

Claims for Plan Benefits. Liberty is both the Initial Claims Reviewer for Claims for Plan Benefits and the Appeals Administrator for denied Claims for Plan Benefits.

Authority of Administrators and Your Rights Under ERISA

The Claims Administrators have the full, complete, and final discretion to interpret the provisions of the Plan and to make findings of fact in order to carry out their respective Claims decision-making responsibilities.

Interpretations and claims decisions by Claims Administrators are final and binding on Participants (except to the extent the Initial Claims Reviewer is subject to review by the Appeals Administrator). After you have appealed the initial determination, if you are not satisfied with the Appeals Administrator's final written decision, you may file a civil action against the Plan under section 502 of the Employee Retirement Income Security Act (ERISA) in a federal court. Please see Section 11. Litigation for the deadline for filing 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.

Time Limitation for Filing a Claim and Filing Proof of Claim

Claims for Plan Benefits. In general, you must have filed a Claim for Plan Benefits within 30 days after the date your qualifying disability begins, and you must have filed your proof of the Disability within 30 days of the request for such proof; otherwise your Claim for Plan Benefits will be denied (unless there are extenuating circumstances as determined by the Claims Administrator).

Claims for Eligibility Determinations. You must have filed a Claim for an Eligibility Determination no later than 30 days after your last day on the payroll of Dow.

Proof of Disability

If you are being paid monthly LTD benefits, the Claims Administrator has the right to request proof of Disability or Partial Disability as often as it reasonably chooses. Monthly Benefits will not be paid with respect to your Disability or Partial Disability if you fail to provide proof that is satisfactory to Liberty when you file an LTD claim, or later when Liberty asks for it, that such disability exists and/or continues to exist; nor for any period of time during which you are not under the care of a doctor for that Disability. See Section 3.E. Proof of Disability and Continuing Proof of Disability.

CLAIMS FOR ELIGIBILITY DETERMINATIONS

Information Required In Order to Be a "Claim"

A Claim for an Eligibility Determination must be in writing and contain the following information:

- The name of the Employee
- The name of benefit plan for which the eligibility determination is being requested (The Rohm and Haas Long Term Disability Program -- Certain Non-Bargained Employees)

Claims for Eligibility Determinations must be sent to:

North America Health and Welfare Plans Leader
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Initial Claims Reviewer for Rohm and Haas Long Term Disability Program -- Certain Non-Bargained Employees

Initial Determination

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

needed, and state when it will make its determination. If the Initial Claims Reviewer denies the Claim, the written notification of the Claims decision will state the reason(s) why the Claim was denied and refer to the pertinent Plan provision(s). If the Claim was denied because you did not file a complete Claim or because the Initial Claims Reviewer needed additional material or information, the Claims decision will state that as the reason for denying the Claim and will explain why such information was necessary.

Appealing the Initial Determination

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

- Employee's name
- Name of the Plan (The Rohm and Haas Long Term Disability Program)
- Reference to the Initial Determination
- Explanation of the reason why you are appealing the Initial Determination

Appeals of Claims for Eligibility Determinations should be sent to:

Associate Director of North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Appeals Administrator for Rohm and Haas Long Term Disability Program -- Certain Non-Bargained Employees (Appeal of Eligibility Determination)

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

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

The Appeals Administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days after the written request for appellate review, except that under special circumstances, the Appeals Administrator may have up to an additional 60 days to provide written notification of the final decision. If the Appeals Administrator needs such an extension, s/he will notify you prior to the expiration of the initial 60 day period, state the reason why such an extension is needed, and indicate when s/he will make his or her determination. If an extension is needed because the Appeals Administrator determines that s/he does not have sufficient information to

make a decision on the Claim, s/he will describe any additional material or information necessary to submit to the Plan, and provide you with the deadline for submitting such information. The period for deciding your Claim may, in the Appeals Administrator's sole discretion, be tolled until the date you respond to a request for information. If you do not provide the information by the deadline, the Appeals Administrator may decide the Claim without the additional information.

If the Appeals Administrator has determined that its final decision is to deny your Claim, the written notification of the decision will state the reasons(s) for the denial and refer to the specific plan provisions on which the denial is based.

CLAIMS FOR PLAN BENEFITS

To submit a Claim for Plan benefits, you must complete a claim form and provide documentation showing that you were Totally Disabled during and for the time required under the Plan. Contact the HR Service Center at:

North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Plan Administrator for Rohm and Haas Long Term Disability Program

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

Group Benefits Disability Claims
Liberty Life Assurance Company of Boston
P.O. Box 7211
London, KY 40742-7211

Initial Determination

When you submit a Claim for disability benefits to Liberty, the Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim.

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

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

- The specific reason or reasons for denial of the claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary;
- If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request;
- If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- An explanation of the Plan's appeal procedures and the applicable time limits; and
- A statement of your right to bring a civil action under section 502(a) of ERISA, if your claim is denied upon review.

Appealing the Initial Determination

If the Initial Claims Reviewer has denied your Claim, you may appeal the decision. In addition, if you were being paid benefits and you have been notified that these benefits will be terminated, you may also appeal the decision to terminate your benefits. You must file a written appeal within 180 days of the Initial Claims Reviewer's notice of denial, assuming that there are not extenuating circumstances, as determined by the Appeals Administrator, in which case the time to file the appeal may be more than 180 days. Appeals must be in writing and must include the following information:

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

Send your appeal to:

Group Benefits Disability Claims
Liberty Life Assurance Company of Boston
P.O. Box 7211
London, KY 40742-7211
Attention: Claims Administrator for Rohm and Haas Long Term Disability Program (Appellate Review)

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

After the Appeals Administrator receives your written request to appeal the initial determination, the Appeals Administrator will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The Appeals Administrator will take into account all comments, documents, records, etc. submitted to the Appeals Administrator that is related to the Claim without regard to whether such information was submitted or considered in the initial determination. The Appeals Administrator will not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

The Appeals Administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 45 days of the written request for appellate review, except that under special circumstances, the Appeals Administrator may have up to an additional 45 days to provide written notification of the final decision. If the Appeals Administrator needs such an extension, it will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the period for deciding your Claim may, in the Appeals Administrator's sole discretion, be tolled from the date on which the notification of extension is sent to you until the date on which you respond to the request for additional information. If you do not provide the additional information within 45 days, the Appeals Administrator will decide the Claim

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

- The specific reason(s) why the Claim you appealed is being denied;
- References to the specific Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;
- If an adverse decision is based on advice of medical or vocational experts, a statement that you may, upon request and free of charge, obtain the identity of the expert whose advice was obtained, without regard to whether the advice was relied upon in making the adverse decision;
- If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request;
- If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- A statement of your right to bring a civil action under section 502(a) of ERISA.