Plan Document and Summary Plan Description for

The Dow Chemical Company Long Term Care Program's

The Dow AgroSciences Long Term Care Insurance Plan

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Effective January 1, 2013 and thereafter until superseded.

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.

Owner: Melinda Theis
LIT: 318-61121

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Owner: Melinda Theis
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Introduction

The Dow AgroSciences Long Term Care Insurance Plan (the "Plan") is a component of The Dow Chemical Company Long Term Care Program (the "Program"). Effective January 1, 2013, The Dow Chemical Company hereby amends and restates the Plan Document for the Plan. This amended and restated Plan Document supersedes the Plan Document dated November 1, 1997. The purpose of the Plan is to provide eligible Employees, Retirees, and their Qualifying Dependents coverage under the Master Group Policy if they choose to participate in it and are otherwise eligible to do so, which will help them to pay for costs and services associated with long-term care needs. The Plan is a welfare benefit plan and is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

Effective January 1, 2006, participants in the Plan could continue coverage under either the Plan or the Program. No new enrollments were accepted under the Plan on or after January 1, 2006. Effective January 1, 2008, the Plan was merged into the Program.

The terms and provisions of the plan document for the Program, to the extent applicable, are incorporated herein by reference.

This document is the Plan Document and Summary Plan Description ("SPD") for the Plan. Any reference to "plan document" or "summary plan description" with respect to this Plan is a reference to the document herein. This Plan Document and SPD contains important information about benefits under the Plan. However, it does not contain all of the information. Further information can be found in the plan document for the Program and the Master Group Policy, both of which are an integral part of the Plan Document and SPD. A copy of the plan document for the Program is available upon request of the Plan Administrator at the contact information listed in "ERISA Information," on page 7. A copy of the Master Group Policy is attached as Appendix A. In the case of a conflict among the Plan Document, SPD, and Master Group Policy, the most recent Master Group Policy shall control.

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

This Plan Document and SPD does not constitute a contract of employment.

Capitalized words in this Plan Document and SPD are defined either in this Plan Document and SPD or in the plan document for the Program. As used herein, the "Company" or "Dow" refers collectively to The Dow Chemical Company and its subsidiaries and affiliates authorized to participate in the Plan. A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

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

Eligibility: No New Entrants

Before January 1, 2006, only Employees, Retirees and Qualifying Dependents were eligible to participate in the Plan. Effective January 1, 2006, the Plan was closed to new participants. Employees, Retirees and Qualifying Dependents who were Participants in the Plan on December 31, 2005, continue to participate in the Plan under the terms of the Plan then in effect.

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Costs (Premiums for Coverage)

Plan benefits are provided under the Master Group Policy (Appendix A: Master Group Policy). You pay the entire cost for coverage. The Company does not subsidize or underwrite any of the costs, including administrative fees, for coverage under this Plan. You pay the entire premium costs for coverage under the Plan (including for Qualifying Dependents) through direct billing or automatic bank withdrawal by John Hancock.

Benefits

The benefits and covered services provided under the Plan are described in the Master Group Policy (Appendix A: Master Group Policy). Benefits and coverage end at the time described in the Master Group Policy.

Information Exchange by Program Business Associates

Dow and the Plan Administrator have contracted with business associates for various services. Claims information concerning Participants and Participant-identifying information such as Social Security numbers may be transferred or shared among the various business associates. Dow may use aggregate data and summary health information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to evaluate Program design changes and premium sharing ratios. The Program's business associates have or will have entered into a contract with Dow and/or the Plan Administrator to protect individually identifiable health information in accordance with HIPAA. For more information, see the "NOTICE OF PRIVACY PRACTICES," on page 14.

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 Program.

The Plan's Assets

John Hancock Demutualization

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 (U.S.A.), a subsidiary of John Hancock Financial Services, Inc. As a result, the Participating Employer, 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. The Participating Employer transferred 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 Participants"). 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 sole 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:

6,876 x A% = B = Stock allocated to Eligible Stock Participant

A% = Amount of premium paid for the 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.

Plan Assets Not from John Hancock Demutualization

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, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as the Plan is amended from time to time, 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, attorneys' fees, third-party administrator fees, and other administrative expenses.

Your Legal Rights Under ERISA

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

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

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

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

Enforce your rights: Under ERISA, there are steps you can take to enforce the legal rights described above. For instance, if you request Plan materials and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the

materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Plan Benefits that is denied or ignored, in whole or in part, you may file suit in state or Federal court.

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

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

Plan Administrator's Discretion

The Plan Administrator is each of the Vice President, HR Center of Expertise; 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 Section 7.4 of the plan document for the Program as a named fiduciary with respect to the Program. 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 this Plan Document and SPD and other relevant Program 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 Program, and if their interpretations or determinations are challenged in court, they shall not be overturned unless proven to be arbitrary or capricious. See "CLAIMS PROCEDURES APPENDIX," starting on page 8, for information about the Claims Administrator's discretion.

Welfare Benefits

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

Dow's Right to Terminate or Amend the Plan

The Dow Chemical Company reserves the right to amend, modify, or terminate the Plan (and/or any underlying plans thereof) at any time in its sole discretion. The procedures for amending, modifying and terminating the Plan are contained in the plan document for the Program.

Disposition of Plan Assets if the Plan is Terminated

If the Company terminates the Plan, the assets of the Plan, if any, shall not be used for the benefit of the Company, but may be used to:

(1) Provide benefits for Participants in accordance with the Plan;

(2) Pay third parties to provide such benefits;

(3) Pay expenses of the Plan and/or the Trust (if any) holding the Plan's assets; and/or

(4) Provide cash for Participants, as long as the cash is not provided disproportionately to officers, shareholders, or highly compensated employees.

Funding

Plan benefits are provided under an insurance policy underwritten by John Hancock Life Insurance Company (U.S.A.). Participants pay the entire premium costs for coverage under the Plan.

Litigation and Class Action Lawsuits

Litigation

If you wish to file a lawsuit against the Program (1) to recover benefits you believe are due to you under the terms of the Program or any law; (2) to clarify your right to future benefits under the Program; (3) to enforce your rights under the Program; or (4) to seek a remedy, ruling or judgment of any kind against the Program or the Program fiduciaries or parties-in-interest (within the meaning of ERISA) that relates to the Program, you 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 Program or to clarify your right to future benefits under the terms of the Program, the earliest of: (a) the date the first benefit payment was actually made, (b) the date the first benefit payment was allegedly due, or (c) the date the Program first repudiated its alleged obligation to provide such benefits;
2. in the case of a claim or action to enforce an alleged right under the Program (other than a Claim for Plan Benefits), the date the Program first denied your request to exercise such right; or
3. in the case of any other claim or action, the earliest date on which you knew or should have known of the material facts on which the claim or action is based, regardless of whether you were aware of the legal theory underlying the claim or action.

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

Class Action Lawsuits

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

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

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

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

For More Information

If you have questions about Plan benefits or enrollment, contact John Hancock at (800) 582-4369. You can also call the HR Service Center for general plan information.

IMPORTANT NOTE

This is the Plan Document and SPD for The Dow AgroSciences Long Term Care Insurance Plan.

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

The Plan Document and SPD 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 Plan Document, SPD and the Program had never existed.

ERISA Information

THE DOW AGROSCIENCES LONG TERM CARE INSURANCE PLAN	
Type of Plan	Long-term care insurance
Type of Plan Administration	Insurer administration
Plan Sponsor	The Dow Chemical Company Employee Development Center Midland, Michigan 48674 877-623-8079
Claims Administrator	John Hancock Life Insurance Company (U.S.A.) Group Long-Term Care Department, B-6 P.O. Box 111 Boston, MA 02117-0111
Employer Identification Number	38-1285128
Plan Number	560
Group Policy Number	28215-LTC
Plan Administrator	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 877-623-8079
To initiate a Claim or appeal a Claim	See "CLAIMS PROCEDURES APPENDIX," starting on page 8.
To Serve Legal Process	General Counsel The Dow Chemical Company 2030 Dow Center Midland, MI 48674
Plan Year	Fiscal records are kept on a plan year basis beginning January 1 and ending December 31.
Funding	Plan participants pay the entire cost of the coverage. The Plan is totally funded by an insurance contract with John Hancock. The assets of the Plan, if any, may be used at the discretion of the Plan Administrator to pay for any benefits provided under the Plan, as amended from time to time, as well as to pay for any expenses of the Plan. Such expenses may include, and are not limited to, consulting fees, actuarial fees, attorneys' fees, third-party administrator fees and other administrative expenses.

CLAIMS PROCEDURES APPENDIX

A "*Claim*" is a written request by a claimant for a benefit under the Plan or for a determination of eligibility under the Program. There are two kinds of Claims:

- A *Claim for Plan Benefits* is a request for plan benefits.
- 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 Claims for Plan Benefits or Claims for an Eligibility Determination, whichever applies to your situation. 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?

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 applicable Claims Administrator will make the decision as to whether to approve or deny your claim.

The initial determination for a Claim is made by the Initial Claims Reviewer. If you appeal, the appellate decision is made by the Appeals Administrator.

- For a Claim for an Eligibility Determination, the Initial Claims Reviewer is the North America Health and Welfare Plans Leader, and the Appeals Administrator is the Associate Director of North America Benefits.
- For a Claim for Plan Benefits, John Hancock is the Initial Claims Reviewer and the Appeals Administrator.

Authority of the Claims Administrator and Your Rights Under ERISA

The Claims Administrator 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 decision-making responsibilities. Interpretations and claims decisions by the Claims Administrator are final and binding on Participants. After you have appealed the initial determination, if you are not satisfied with the final appellate decision, you may file a civil action against the Plan under Section 502 of the Employee Retirement Income Security Act ("ERISA") in federal court. Please see "Litigation," on page 5 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 Participant. The Program will recognize a person as a Participant's "authorized representative" if such person submits a notarized writing signed by the Participant stating that the authorized representative is authorized to act on behalf of such Participant. A court order stating that a person is authorized to submit Claims on behalf of a Participant also will be recognized by the Program.

HOW TO FILE A CLAIM FOR PLAN BENEFITS

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

John Hancock Life Insurance Company (U.S.A.)
Group Long-Term Care Department, B-6
P.O. Box 111

Boston, MA 02117-0111
(800) 582-4369
Attention: Clams Administrator for The Dow AgroSciences Long Term Care Insurance Plan

You can obtain a Certification of Need Form by calling John Hancock at the telephone number above. When the John Hancock case manager calls you, you should explain that you want to file a Claim for Plan Benefits. The case manager will explain the certification process, go over relevant Plan requirements with you, and begin to gather information about your care needs. The case manager will send you a Certification of Need form.

Initial Determination

Once you have completed and submitted a Certification of Need form to John Hancock, the Initial Claims Reviewer will review and notify you of its decision to approve or deny your Claim. This notification will be provided to you in writing within a reasonable period, not to exceed 90 days of the date you submitted your form; 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 Your Claim Is Denied

If the Initial Claims Reviewer denies your Claim (for example, because you do not meet the certification requirements for ADL dependency or you are not cognitively impaired), 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.

HOW TO FILE A CLAIM FOR AN ELIGIBILITY DETERMINATION

In order to submit a Claim for an Eligibility Determination, the Claim must be in writing and contain the following information:

- The name of the Employee or Retiree
- The name of the plan for which the eligibility determination is being requested

A Claim for an Eligibility Determination 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 The Dow AgroSciences Long Term Care Insurance Plan

Initial Determination

If you submit a Claim for an Eligibility Determination, the Initial Claims Reviewer will review your Claim and notify you of its decision to approve or deny your Claim. Such notification will be provided to you in writing within a reasonable period, not to exceed 90 days of the date you submitted your claim; except that under special circumstances, the Initial Claims Reviewer 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.

IF YOU WANT TO APPEAL A DENIAL OF YOUR CLAIM

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. Your written appeal must include the following information:

- Your name, employee number, and Social Security number
- The Insured's name and Social Security number
- Name of the benefit Plan (The Dow AgroSciences Long Term Care Insurance Plan, Policy Number 28215 – LTC)
- Reference to the initial determination
- An explanation of the reason why you are appealing the initial determination.

Appeals of Claims should be sent to:

For a Claim for Plan Benefits:
Director of Case Management
John Hancock Life Insurance Company (U.S.A.)
Group Long-Term Care Department, B-6
P.O. Box 111
Boston, MA 02117-0111
(800) 582-4369
Attention: Appeals Administrator for The Dow AgroSciences Long Term Care Insurance Plan

For a Claim for an Eligibility Determination:
Associate Director of North America Benefits
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Appeals Administrator for The Dow AgroSciences Long Term Care Insurance Plan

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 are relevant to your Claim, as determined by the Appeals Administrator in its sole discretion. Your request must be in writing. Such information will be provided at no cost to you.

After the Appeals Administrator receives your written request to appeal the initial determination, it 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 not be the same person as, or a subordinate who reports to, the person who made the initial decision to deny the Claim. The Appeals Administrator will notify you in writing of its final decision. Such notification will be provided within a reasonable period, not to exceed 60 days of the written request for appellate review, except that under

special circumstances, the Appeals Administrator may have up to an additional 60 days to provide written notification of the final decision.

If the Appeals Administrator needs such an extension, it will notify you prior to the expiration of the initial 60-day period, state the reason why such an extension is needed, and indicate when it will make its determination. If an extension is needed because the Appeals Administrator determines that it does not have sufficient information to make a decision on the Claim, it will describe any additional material or information necessary to submit to the 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 will decide the Claim without the additional information.

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

GLOSSARY OF TERMS

Additional defined terms are in the plan document for the Program.

Dow AgroSciences Pension Plan
The Dow AgroSciences Pension Plan or its successor. The Dow AgroSciences Pension Plan was merged into the Dow Employees Pension Plan, effective January 1, 2006.

Employee
A person who: (1) is classified by the Participating Employer as a "regular full time" or "regular less than full time" employee, (2) is scheduled to work at least twenty (20) hours each week, (3) is employed by a Participating Employer to perform personal services in an employer-employee relationship which is subject to taxation under the Federal Insurance Contributions Act or similar federal statute, (4) receives payment for services performed for the Participating Employer directly from the payroll of the Participating Employer, and (5) does not receive compensation for such services performed for the benefit of a Participating Employer from either (i) a source other than the payroll of the Participating Employer or (ii) an entity that is not the Participating Employer. The definition of "Employee" does not include an individual (1) who is classified by the Participating Employer as a "temporary" employee or an "intern", (2) who performs services for the benefit of the Participating Employer in a relationship characterized by both the Participating Employer and the individual as an "independent contractor" and receives payment from the Participating Employer for such services performed for the Participating Employer from a source other than the payroll of the Participating Employer, or (3) performs services for the benefit of a Participating Employer but whose compensation for such services is paid by an entity that is not the Participating Employer; such individuals are not an "Employee" (with a capital "E") for purposes of eligibility to participate in the Plan even if such individuals are determined by a regulatory agency to be a "common law employee" or "leased employee" of a Participating Employer.

Harbor Beach Cash Balance Retirement Plan
The Harbor Beach Cash Balance Retirement Plan or its successor. The Harbor Beach Cash Balance Retirement Plan was merged into the Dow AgroSciences Pension Plan.

Married or Marriage
A legally valid marriage between a man and a woman recognized by the state in which the man and the woman reside.

Master Group Policy
The John Hancock Life Insurance Company Policy #28215 LTC issued to Dow AgroSciences LLC.

Participant
Each Employee, Retiree, or other eligible person who participates in the Plan as described in "Eligibility: No New Entrants," on page 1.

Participating Employer
Dow AgroSciences, LLC and any other corporation or business entity The Dow Chemical Company authorizes to participate in the Plan with respect to its Employees.

Plan
The Dow AgroSciences Long Term Care Insurance Plan, together with any and all amendments and supplements hereto.

Owner: Melinda Theis
LIT: 318-61121

Qualifying Dependent
A person who is: (1) the Spouse of an Employee or Retiree, or (2) the parent or grandparent of an Employee or Retiree or Spouse of an Employee or Retiree; or the surviving Spouse of an Employee or Retiree. The terms "parent" or "grandparent" as used in this Plan means a person with respect to whom an Employee, Retiree, Spouse of an employee or Retiree, or parent of an Employee, Retiree, or Spouse of an Employee or Retiree, as the case may be, is the biological child, step-child, foster child, or legally adopted child. The parent or grandparent of an Employee, Retiree or Spouse of an Employee or Retiree must be less than age 80 on his or her effective date of coverage. The Spouse of an Employee or Retiree must be age 18 or older on his or her effective date of coverage.

Retire or Retirement
When (i) a former Employee is eligible for a normal or early retirement benefit under the Dow AgroSciences Pension Plan, or (ii) at the time of separation from employment, the active Employee is a participant in the Harbor Beach Cash Balance Retirement Plan and is age 65 or older, or age 50 or older with at least 10 years of Service.

Retiree
A former Employee who Retires from the Participating Employer; provided, however, that for the avoidance of doubt a former Employee shall not be considered a Retiree if the former Employee: (1) separates from employment and is eligible only for a deferred vested benefit under the Dow AgroSciences Pension Plan at the time of separation from employment or (2) is a participant in the Harbor Beach Cash Balance Retirement Plan and separates from employment under age 50 or between ages 50 and 65 with less than 10 years of Service.

Service
"Eligibility Service" or "Credited Service," as the case may be, as those terms are defined under the Dow AgroSciences Pension Plan.

Spouse
A person who is Married to the employee.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: August 20, 2013.

The Dow Chemical Company Medical Care Program, The Dow Chemical Company Retiree Medical Care Program, The Dow Chemical Company Dental Assistance Program, The Dow Chemical Company Retirement Health Care Assistance Plan (RHCAP), The Dow Chemical Company Health Care Reimbursement Account, The Dow Chemical Company Executive Physical Examination Program (health care component only), The Dow Chemical Company Long Term Care Program; the Union Carbide Corporation Retiree Medical Care Program (renamed), Rohm and Haas Company Health and Welfare Plan (collectively referred to in this document as the "Program") are required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Program's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Program's duties with respect to your PHI;
- your right to file a complaint with the Program and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Program's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information created, received, transmitted or maintained by the Program.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information. In addition, the Program may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health Program, which summarizes the claims history, claims expense or type of claims experienced by individuals for whom a Program sponsor has provided health benefits under a group health Program; and from which identifying information has been deleted in accordance with HIPAA.

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures:

Upon your request, the Program is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Program's compliance with the privacy regulations.

Uses and disclosures to carry out Treatment, Payment and Health Care Operations:

The Program and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out Treatment, Payment and Health Care Operations. The Program also will disclose PHI to the applicable Plan Sponsor[1] for purposes related to Treatment, Payment and Health Care Operations. As of April 14, 2003, the Plan Sponsors have amended the plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, The Dow Chemical Company Medical Care Program may disclose to a treating orthopedic specialist the name of your treating family physician so that the orthopedic specialist may ask for your X-rays from the treating family physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, The Dow Chemical Company Medical Care Program may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Program.

Health Care Operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, The Dow Chemical Company Medical Care Program may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written Authorization:

In general, your written authorization will be obtained before the Program will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes

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[1] The Plan Sponsor is The Dow Chemical Company for the following plans: for The Dow Chemical Company Medical Care Program, The Dow Chemical Company Retiree Medical Care Program, The Dow Chemical Company Dental Assistance Program, The Dow Chemical Company Retirement Health Care Assistance Plan (RHCAP), The Dow Chemical Company Health Care Reimbursement Account, The Dow Chemical Company Executive Physical Examination Program, and The Dow Chemical Company Long Term Care Program. The Plan Sponsor is Union Carbide Corporation, a wholly-owned subsidiary of The Dow Chemical Company, for the following plan: Union Carbide Corporation Retiree Medical Care Program.

about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Program may use and disclose such notes when needed by the Program to defend against litigation filed by you.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or Payment for that care; and
- you have either agreed to the disclosure, have been given an opportunity to object and have not objected, or the Program reasonably infers from the circumstances that you would not object to the disclosure.

Your written authorization is required before your PHI may be disclosed for most marketing purposes or disclosures that constitute a sale of PHI.

You may revoke your authorization in writing for these uses and disclosures at any time, but the revocation will not affect any disclosure made prior to the receipt of the revocation.

Uses and disclosures for which consent, authorization or opportunity to object is not required:

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. To a business associate (e.g., a contractor) retained to perform services on behalf of the Program when the business associate has agreed to safeguard your PHI.

2. When required by law.

3. When permitted for purposes of public health activities, included when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

4. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be the victim of abuse, neglect or domestic violence. In such case, the Program will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

5. The Program may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate

oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

6. The Program may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Program that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

7. When required for law enforcement purposes (for example, to report certain types of wounds).

8. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Program's best judgment.

9. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

10. The Program may use or disclose PHI for research, subject to conditions.

11. When consistent with the applicable law and good standards of ethical conduct if the Program, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

<u>Prohibited Uses and Disclosures:</u>

The Program may not use or disclose PHI that is genetic information for underwriting purposes.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures:

You may request the Program to restrict uses and disclosures of your PHI to carry out Treatment, Payment or Health Care Operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or Payment for your care. However, the Program is not required to agree to your request. The Program will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you indicate that disclosure by the regular means could pose a danger to you and you specify a reasonable alternative address or method of contract. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following person: Privacy Official; ERISA Health Plans; Employee Development Center, Midland, MI 48674.

You have the right to receive notification following a breach of your unsecured PHI.

Right to Inspect and Copy PHI:

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Program maintains the PHI. You have a right to obtain a copy of your PHI in electronic format where it is maintained in one or more designated record sets electronically. You have the right to request that the Program transmit a copy of PHI to another individual at your request.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Program, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Program is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following person: Privacy Official; ERISA Health Plans; Employee Development Center, Midland, MI 48674. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI:

You have the right to request the Program to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Program has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Program is unable to comply with the deadline. If the request is denied in whole or in part, the Program must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following person: Privacy Official; ERISA Health Plans; Employee Development Center, Midland, MI

48674. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make your request for amendment in writing, provide the name of the applicable benefit plan you are requesting the amendment under, and provide the reason(s) to support the amendment you are requesting.

The Right to Receive an Accounting of PHI Disclosures:

At your request, the Program will also provide you with an accounting of disclosures by the Program of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out Treatment, Payment or Health Care Operations; (2) to Individuals about their own PHI; (3) pursuant to an individual's authorization; or (4) prior to the compliance date. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Program may charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request:

To obtain a paper copy of this Notice contact the following person: Health Insurance Portability and Accountability Act (HIPAA) Privacy Official for ERISA Health Plans; Employee Development Center, Midland, MI 48674

A Note About Personal Representatives:

You may exercise your rights through a Personal Representative. A Personal Representative is a person legally authorized to make Health Care decisions on your behalf. Your Personal Representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Program retains discretion to deny access to your PHI to a Personal Representative if the Program has a reasonable belief that you may be subject to domestic violence, abuse, or neglect by the Personal Representative or if the Program reasonably decides that it is not in the best interest to treat that person as your Personal Representative. This also applies to Personal Representatives of minors.

Section 3. The Program's Duties

The Program is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This notice is effective beginning August 20, 2013 and the Program is required to comply with the terms of this notice on and after that date. However, the Program reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Program prior to and after that date. If a privacy practice is changed, a revised version of this notice will be provided participants and beneficiaries for whom the Program still maintains PHI. The notices may be provided in the Choices enrollment brochures and updated versions of the summary plan descriptions, or other appropriate means of communication. Any

revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Program or other privacy practices stated in this notice.

Minimum Necessary Standard:

When using or disclosing PHI or when requesting PHI from another covered entity, the Program will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for Treatment;
- uses or disclosures made to the individual;
- disclosures made to the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures authorized by the individual; and
- uses or disclosures that are required for the Program's compliance with legal regulations.

Section 4. Your Right to File a Complaint With the Program or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Program in care of the following person: Privacy Official; ERISA Health Plans; Employee Development Center, Midland, MI 48674. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Program will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Program for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following person: Privacy Official; ERISA Health Plans; Employee Development Center, Midland, MI 48674.

CONCLUSION: PHI use and disclosure by the Program is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act.) You may find these rules at 45 Code of Federal Regulations parts 160 and 164. This notice attempts to summarize the regulations and set forth the Program's legal duties, privacy practices, policies, and procedures regarding your PHI. The regulations will supersede any discrepancy between the information in this notice and the regulations.

Appendix A: Master Group Policy