Summary Plan Description for:

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

Dow AgroSciences
Long Term Disability
Insurance Plan (LTD)

Amended and Restated
Effective January 1, 2014 and thereafter until superseded

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

Copies of this SPD can be found at the Dow Intranet, the Dow Friends website, or by requesting a copy from the Retiree Service Center, Employee Development Center, Midland, MI 48674, telephone 1-800-344-0661 or accessing the Dow Benefits Website and clicking on Message Center. Summaries of material modifications may also be published from time to time.

Content Steward: Dombek
January 1, 2014
Literature #318-61134

THE DOW CHEMICAL COMPANY
ADOPTION OF SUMMARY PLAN DESCRIPTIONS

WHEREAS, The Dow Chemical Company ("Dow") sponsors The Dow Chemical Company Long Term Disability Program (Applicable to Those Who Were Fully Disabled Prior to January 1, 2008) (the "Program");

WHEREAS, Dow offers the Dow AgroSciences Long Term Disability Insurance Plan (the "Plan") under the Program;

WHEREAS, Dow reserves the right, by action of the undersigned, to amend or modify the Program including, without limitation, the Plan and the Summary Plan Description for the Plan, in accordance with Article VII of the plan document for the Program; and

WHEREAS, Dow wishes to adopt a revised Summary Plan Description for the Plan.

NOW, THEREFORE, BE IT RESOLVED, Dow adopts the following Summary Plan Description for the Plan as amended and restated substantially in the form attached hereto and bearing the following cover:

> Summary Plan Description for:
>
> The Dow Chemical Company
> Long Term Disability Program
> Applicable to Those Fully Disabled Prior to January 1, 2008
>
> Dow AgroSciences Long Term Disability Insurance Plan (LTD)
>
> Amended and Restated
> Effective January 1, 2014 and thereafter until superseded

RESOLVED, FURTHER, that all prior versions of the foregoing Summary Plan Description for the Plan are superseded.

* * * *

By: _____
Bryan Jendretzke
Global Benefits Director
The Dow Chemical Company

Reviewed by Plan Administrator:
_____
Diane Dittenhafer

Reviewed by Legal Department:
_____
Jennifer Manchester

Dated: December 30, 2014

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Overview

This booklet is the Summary Plan Description ("SPD") for the Dow AgroSciences Long Term Disability Insurance Plan (the "Plan"). The Plan is a component plan of The Dow Chemical Company Long Term Disability Program (applicable to those who were fully disabled prior to January 1, 2008), ERISA Plan #506. The Plan provides group long term disability insurance coverage to certain Dow AgroSciences, LLC ("Dow AgroSciences") employees who were Disabled before January 1, 2006. The Plan is closed to those who were not Disabled prior to January 1, 2006. There are no new enrollments in the Plan on or after January 1, 2006.

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

The Plan provides group long term disability insurance coverage through a group insurance contract (the "Policy") with UNUM Life Insurance Company ("UNUM"). UNUM pays the benefits under the Plan. In addition, UNUM is the named fiduciary for making decisions as to whether a Claim for Plan Benefits is payable.

The Plan is governed by the plan document for the Plan, which is the legal instrument under which the Plan is operated. This legal instrument is referred to in this SPD as the "Plan Document."

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 the *ERISA Information* section of this SPD.

The Dow Chemical Company reserves the right to amend, modify and 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 *Glossary appendix* to this SPD, in the Plan Document, or in the Policy.

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

LTD Coverage Options

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

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

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

Eligibility

Plan Closed to New Participants Effective January 1, 2006

Regular Employees of Dow AgroSciences who were actively at work or on an approved Family Leave ***before January 1, 2006, and who became Disabled before January 1, 2006*** were eligible to participate in the LTD Coverage Options described above, after completing 12 months of actual work. Generally, a "regular" Employee means a person who is scheduled to work at least 20 hours each week and is classified by the Company as either a "full-time" or "less than full-time" Employee.

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

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

If you want to file a Claim for an Eligibility Determination because you are not sure whether you are eligible to participate in the Plan, refer to the

Claims Procedures Appendix of this SPD.

If You Transferred to Dow AgroSciences

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

Enrollment

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

Funding and Employee Contribution

Plan benefits are fully funded by insurance through UNUM. Dow AgroSciences paid the entire cost of coverage for the continuation of 50% of your monthly base salary. If you elected the 66 2/3% option, you paid an additional amount for the additional 16 2/3% of coverage based on

your age as of January 1 each year and your monthly base salary on a pre-tax salary reduction basis under The Dow AgroSciences Flexible Spending Plan.

Effective Period of Coverage

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

When Coverage Ends

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

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

Payment of Benefits

You were eligible to receive benefits under the Plan when:

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

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

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

- you are unable to perform each of the material duties of your regular occupation – and, after receiving benefits for 24 months, you cannot perform each of the material duties of any occupation for which you receive pay and for which you have reasonable training, education, experience, or

- you are performing at least one of the basic duties of your regular occupation or another occupation on a part-time or full-time basis and you are earning no more than 80% of your monthly "indexed pre-disability earnings."

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

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

Full Disability Benefit

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

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

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

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

The maximum long term disability benefit you may receive under the Plan is $15,000 per month. The minimum long term disability benefit you may receive under the Plan is the greater of (1) $100 per month, or (2) 10% of the monthly benefit before deductions for other income benefits.

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

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

If your earnings cause your total Plan benefits to exceed 100% of your base salary at the time you were approved for long term disability, your long term disability benefit is required to be reduced so that your total benefits do not exceed 100% of your base salary at the time you were approved for long term disability.

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

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

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

Your adjusted long term disability benefit would be:

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

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

Tax Treatment

Your Plan LTD payments are taxable. UNUM does not withhold taxes from your benefit on a mandatory basis. However, you may request additional withholding by completing a form W-

4S. UNUM will mail you a W-2 statement each year that will report the amount of your taxable LTD benefit and the amount of tax withheld, if any. Because tax laws change, you should consult a professional tax adviser for further information.

When Your Benefit Payments End

Your long term disability benefits under the Plan end:

- when you are no longer considered disabled, as determined by the LTD insurance carrier;
- if you earn income that exceeds 80% of your indexed pre-disability earnings;
- when you die;
- when you reach age 65, if you became disabled prior to age 60; provided that the maximum benefit period is not less than 60 months; or
- according to the following schedule, if you became disabled at age 60 or older:

Age at Which You Become Disabled	Maximum Benefit Period
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

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

Recurring Disabilities

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

Benefits for recurring disabilities are paid subject to the conditions of the prior disability. In addition, you are not be eligible for benefits due to a recurring disability if you are receiving

benefits from any other group long term disability policy, such as one offered by another employer.

If you return to work for Dow AgroSciences on a full-time basis for a period of 90 calendar days or more, a recurring disability is treated as a new period of disability. If you returned to work for Dow AgroSciences after December 31, 2005 for a period of at least 90 calendar days, you are no longer eligible for benefits under the Plan; you may be eligible for LTD benefits under a different Dow-sponsored plan.

Survivor Benefit

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

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

Limitations and Exclusions

The Plan does not pay benefits for disabilities resulting from:

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

Pre-existing Medical Conditions

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

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

Mental Illness Limitation

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

- You are in a hospital or institution at the end of the 24-month period, in which case benefits are paid during the confinement.
    - If you are still disabled when discharged, benefits continue for a recovery period of up to 90 days.
    - If you become reconfined during the recovery period for at least 14 days in a row, benefits are paid during the confinement and another recovery period of up to 90 more days.
- You continue to be disabled and become confined for at least 14 days in a row after the 24-month period, in which case benefits are paid during the confinement.

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

Claiming a Benefit Payment; Proof of Continuing Disability

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

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

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

- seriousness of the disability.

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

Ancillary Benefits

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

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

- **Medical Coverage**. If benefits under the Dow AgroSciences Illness Pay Program were exhausted before you were approved for long term disability benefits, you generally could continue your health care benefits under COBRA continuation coverage. Once you were approved for benefits under the Plan, you were eligible to continue coverage under either The Dow Chemical Company Retiree Medical Care Program or The Dow Chemical Company Insured Health Program for you and your eligible and covered dependents. In general, your cost for coverage is determined according to the retiree cost schedule, based on your years of service as an active Employee. Contact the Retiree Service Center for more information.

- **Medicare.** If you are approved for Social Security disability benefits, you are automatically enrolled in Medicare on the first of the month following 24 months from the date of your disability as determined by Social Security. Dow retiree medical coverage coordinates with Medicare, with Medicare acting as the primary payer. This means that Dow retiree medical coverage supplements the Medicare payments by paying the difference between what Medicare pays and the normal benefits payable under the Dow medical coverage. When Medicare is primary, the Dow retiree medical coverage payments will be based on the assumption that both Medicare coverage Part A (hospital insurance) and Part B (medical insurance) are in effect (whether or not they are).

- **Life Insurance.** While you receive benefits under the Plan, you continue to be eligible for employer-paid life insurance coverage up to one times your annual base salary. In addition, if you were enrolled in supplemental employee-paid life insurance coverage as of your last day as an active Employee, you are eligible for life insurance coverage of an additional one times your annual base salary. Dow currently pays the cost of these coverages.

- **Dependent Life Insurance** and **Accidental Death and Dismemberment Insurance** coverages were terminated on December 31, 2005. The deadline for converting one or both of the terminated coverages to a private policy was January 30, 2006.

- **Business Travel Accident (BTA) Insurance** coverage, and **Occupational Accident Insurance** coverage ended when you were approved for benefit payments under the Plan.

- **Health Care Reimbursement Account (HCRA)** or **Dependent Care Reimbursement Account (DCRA)**. If you were enrolled in HCRA or DCRA, you were permitted to continue coverage only for the year in which you were approved for Plan benefits. You were required to submit any claims under HCRA or DCRA before June 30 of the following year. Any remaining amounts were forfeited as of that date.

- **Savings Plan.** After you were approved for benefit payments under the Plan, you were not permitted to continue to make contributions to the Dow AgroSciences Employee Savings Plan or any successor.

- **Pension Plan.** You may not receive both benefits under the LTD Plan and benefits under the Dow Employees' Pension Plan (the "DEPP," into which the Dow AgroSciences Pension Plan was merged). If you are eligible for both benefits, you must select one plan or the other. Your compensation used in calculating your pension benefit is your earnings as an active Employee before the commencement of your long term disability payments. The following rules also apply following approval to receive Plan benefits:

  - If you were approved for long term disability benefits on or after January 1, 1991 and before January 1, 1994, you earn one year of credited service in the DEPP for each plan year that you receive long term disability benefits before January 1, 1994. Beginning on January 1, 1994 and continuing until your retirement, you earn one-half year of credited service for each plan year that you receive long term disability benefits.

  - If you are approved for long term disability benefits on or after January 1, 1994, you earn one-half year of credited service in the DEPP for each plan year that you receive long term disability benefits until your retirement.

  - If you are hired on or after January 1, 1996, you earn one-half year of eligibility service in the DEPP for each plan year you receive long term disability benefits, but only if you have completed five years of vesting service as of the date you are approved to receive long term disability benefits.

  - If you were hired on or before December 31, 1996 and are receiving long-term disability benefits, you are credited with one year of vesting service in the DEPP for each plan year you receive long term disability benefits. If you were hired on or after January 1, 1997 and are receiving benefits under the Plan, you are not credited with any vesting service during any plan year in which you receive long term disability benefits unless you accumulate 1,000 or more hours of regularly scheduled work during that plan year.

Tax Treatment of Coverage and Benefits

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

Since tax laws change, you should consult a professional tax advisor for further information. Neither the Company, nor any other Participating Employer or any other affiliate, makes any assertion or warranty about whether any taxes are required by any government or government agency to be withheld from, or paid with respect to, amounts paid under the Plan. The Participant shall bear all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

Payment of Unauthorized Benefits

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

- The amount of any other benefit paid to, or on behalf of, such Participant may be reduced by the amount of the excess payment.

- The Plan Administrator may require the Participant to reimburse the Plan for benefits paid, including reasonable interest.

- If the person does not reimburse the Plan by the date determined by the Plan Administrator, the Plan Administrator may cancel coverage for the Participant and refuse re-enrollment.

The Plan Administrator may elect recoupment or reimbursement regardless of whether the excess benefit was provided by reason of the Plan Administrator's error or by reason of false, misleading, or inaccurate information furnished by the Participant.

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, retroactively from 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 or determine that you are not eligible for coverage under the Plan. In addition, the Plan and/or Dow may pursue civil and/or criminal action against you, or take other legal action. The employer may terminate your employment. If you are terminated from eligibility under any benefit plan sponsored by the Company or an affiliate because of a violation

of a similar section of that benefit plan, the Plan Administrator may determine that you are not eligible for coverage under 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 (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), the Plan Documents and the latest annual reports (if applicable) 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 (if applicable), 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, if the Plan is required to furnish such a report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if the Plan is required to furnish such a 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 a copy of plan documents or the latest annual report 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.

Plan Administrator's Discretion

The Plan Administrators are the Vice President, Human Resources Center of Expertise; the Global Benefits Director; Associate Director of North America Benefits; and North America Health and Welfare Plans Leader. The Company may also appoint other persons, groups of persons, or entities as named fiduciaries of the Plan. The Plan Administrator, Claims Administrators, and other Plan fiduciaries, each acting individually, have the sole and absolute discretion to interpret the Plan Document (including this SPD), make determinations, make findings of fact, and adopt rules and procedures applicable to matters they are authorized to decide. Such interpretations and determinations are conclusive and binding on all persons claiming benefits under, or otherwise having an interest in, the Plan, and if challenged in court, such interpretations and determinations shall not be overturned unless proven to be arbitrary or capricious. For a detailed description of the Plan Administrator's and Claim Administrators' authority, see the Plan Document and the "

Claims Procedures Appendix"

Plan Document

The Plan will be administered in accordance with its terms. If the VPHR determines that the applicable Plan Document or this SPD has a drafting error (sometimes called a "scrivener's error"), the applicable Plan Document or SPD will be applied and interpreted without regard to that error. The determination of whether there is a scrivener's error, and how to apply and interpret the Plan in the event of a scrivener's error, will be made by the VPHR, in the exercise of his best judgment and sole discretion, based on his understanding of the Company's intent in establishing the Plan and taking into account all evidence (written and oral) that he deems appropriate or helpful.

No Government Guaranty of Welfare Benefits

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

Amendment, Modification or Termination of Plan

The Company reserves the right to amend, modify, or terminate the Plan (including amending the Plan Document and the SPD), at any time, for any reason, in its sole discretion, with or without notice, retroactively or prospectively, to the full extent permitted by law. The procedures for amending, modifying, and terminating the Plan are contained in the Plan Document.

If the Company terminates the Plan, the assets of the Plan, if any, shall be used to:

1. provide benefits under the Plan and pay expenses of administering the Plan; or

2. provide cash for Participants, in accordance with applicable law.

Litigation

If you wish to file a lawsuit against the Plan (a) to recover benefits you believe are due to you under the terms of the Plan or any law; (b) to clarify your right to future benefits under the Plan; (c) to enforce your rights under the Plan; or (d) 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. However, neither this paragraph nor the Applicable Limitations Period applies to a claim governed by section 413 of ERISA.

The Applicable Limitations Period is the period ending one year after:

1. in the case of a claim or action to recover benefits allegedly due to you under the terms of the 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 or action to recover 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.

If a lawsuit is filed on behalf of more than one individual, the Applicable Limitations Period applies separately with respect to each individual.

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

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

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.

Privilege

If the Company or a Participating Employer (or a person or entity acting on behalf of the Company or a Participating Employer) or an Administrator or other Plan fiduciary (an "Advisee") engages attorneys, accountants, actuaries, consultants, and other service providers (an "Advisor") to advise them on issues related to the Plan or the Advisee's responsibilities under the Plan:

- the Advisor's client is the Advisee and not any Employee, Participant, claimant, or other person;

- the Advisee shall be entitled to preserve the attorney-client privilege and any other privilege accorded to communications with the Advisor, and all other rights to maintain confidentiality, to the full extent permitted by law; and

- no Employee, Participant, claimant or other person shall be permitted to review any communication between the Advisee and any of its or his Advisors with respect to whom a privilege applies, unless mandated by a court order.

Waiver

A term, condition, or provision of the Plan shall not be waived unless the purported waiver is in writing signed by the Plan Administrator. A written waiver shall operate only as the specific term, condition, or provision waived and shall remain in effect only for the period specifically stated in the waiver.

Providing Notice to Administrator

No notice, election or communication in connection with the Plan that you, a claimant, or other person makes or submits will be effective unless duly executed and filed with the appropriate Administrator (including any of its representatives, agents, or delegates) in the form and manner required by the appropriate Administrator.

No Assignment of Benefits

Except as otherwise provided in the Plan Document or an applicable Incorporated Document, or to the extent permitted or required by law, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge of any kind.

Incompetent and Deceased Participants

Except as otherwise provided in an applicable Incorporated Document:

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

- Payments due to deceased Participants from claims made under the Plan shall be made to the Participant's estate.

For More Information

If you have questions, contact the Retiree Service Center at 1-800-344-0661 or access the Dow Benefits website and click on Message Center.

IMPORTANT NOTE

This booklet is the Summary Plan Description (SPD) for the Dow AgroSciences Long Term Disability Insurance Plan (the "Plan"). However, this booklet is not all-inclusive and it is not intended to take the place of the Plan's legal documents.

Dow 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.

ERISA Information

Dow AgroSciences
Long Term Disability Insurance Plan

Plan Sponsor:	The Dow Chemical Company Employee Development Center Midland, Michigan 48674
Employer Identification Number:	38-1285128
Plan Number:	506
Policy Number:	500781
Plan Administrator:	North America Health and Welfare Plans Leader The Dow Chemical Company Employee Development Center Midland, Michigan 48674 (800)-344-0661
Plan Type:	A welfare benefit plan which provides benefits to partially replace income lost due to an approved disability.
Funding:	Benefits are funded through a group insurance contract with UNUM Life Insurance Company. Insurance premiums were paid by company contributions, and in some cases, by Employee contributions.
Claims Administrator for Claims for Eligibility Determination	*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 Dow AgroSciences Long Term Disability Insurance Plan *Appeals Administrator:* Associate Director of North America Benefits or the Global Benefits Director The Dow Chemical Company Employee Development Center Midland, MI 48674 Attention: Appeals Administrator for The Dow AgroSciences Long Term Disability Insurance Plan

Claims Administrator for Claims for Plan Benefits	UNUM Life Insurance Company administers claims under a group policy. The address and telephone number for UNUM Life Insurance Company are: UNUM Life Insurance Company The Benefits Center P.O. Box 100158 Columbia, SC 29202-3158 (800) 858-6843
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.

Claims Procedures Appendix

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.
- 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. See the section entitled *CLAIMS FOR PLAN BENEFITS* for the procedures regarding Claims for Plan Benefits. See the section entitled *CLAIMS FOR AN ELIGIBILITY DETERMINATION* 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. The initial determination is made by the Initial Claims Reviewer. If you appeal an initial determination, the appellate decision is made by the Appeals Administrator. Each of the Claims Administrators is a named fiduciary of the Plan with respect to the respective types of Claims that they process.

Claims for an Eligibility Determination: The Initial Claims Reviewer is the North America Health and Welfare Plans Leader for The Dow Chemical Company or his delegate. The Appeals Administrators are the Global Benefits Director and the Associate Director of North America Benefits for The Dow Chemical Company.

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

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. However, the Claims Administrators' determinations are subject to the interpretation of the Plan Document made by the Plan Administrator.

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). You may file a civil action against the Plan under section 502 of the Employee Retirement Income Security Act (ERISA) in a federal court, provided you complete the claims procedures described in this Appendix (or the Claims Administrator fails to timely respond to your claim). If the Claim Administrators' determinations are challenged in court, they shall not

be overturned unless proven to be arbitrary and capricious. Please see the *Litigation* section 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

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

Claims for an Eligibility Determination

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

CLAIMS FOR AN ELIGIBILITY DETERMINATION

Information Required In Order to Be a "Claim"

For Claims that are requests for *Eligibility Determinations*, the Claims 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

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: Administrator for the Dow AgroSciences Long Term Disability 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 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. The decision will also describe the appeals procedures (also described below).

Appealing the Initial Determination

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

- Employee's name
- The relationship of the person requesting an Eligibility Determination to the Employee
- Name of the Plan
- Reference to the Initial Determination
- Explanation of the reason why you are appealing the Initial Determination

Appeals of Eligibility Determination Claims should be sent to:

Associate Director of North America Benefits or the Global Benefits Director
The Dow Chemical Company
Employee Development Center
Midland, MI 48674
Attention: Administrator for the Dow AgroSciences Long Term Disability Insurance Plan (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.

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

CLAIMS FOR PLAN BENEFITS

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

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

(800) 344-0661

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

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

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

Initial Determination

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

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

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

- The specific reason or reasons for denial of the claim;
- References to the specific Plan provisions upon which such denial is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary;
- If applicable, any internal rule, protocol, guideline or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon and a copy will be provided free of charge upon request;
- If the decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse

decision, or a statement that such explanation will be provided free of charge upon request;

- An explanation of the Plan's appeal procedures and the applicable time limits; and
- A statement of your right to bring a civil action under section 502(a) of ERISA, if your claim is denied upon review.

Appealing the Initial Determination

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

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

Send your appeal to:

UNUM Life Insurance Company
LTD Claims Unit, B098
2211 Congress Street
Portland, Maine 04122
Attention: Claims Administrator for the Dow AgroSciences Long Term Disability Insurance Plan (Appellate Review)

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

After the Appeals Administrator receives your written request to appeal the initial determination, the Appeals Administrator will review your Claim. Deference will not be given to the initial adverse decision, and the Appeals Administrator will look at the Claim anew. The Appeals Administrator will take into account all comments, documents, records, etc. submitted to the Appeals Administrator that is related to the Claim, without regard to whether such information was submitted or considered in the initial determination. The Appeals Administrator will not be the same person as, or a subordinate who reports to, the person who made the initial decision to

deny the Claim. If the adverse decision is based on medical judgment, the Appeals Administrator will consult a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional may not be the same person consulted for the initial determination, and may not be a subordinate who reports to the person who was consulted for the initial determination.

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

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

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

- A statement of your right to bring a civil action under section 502(a) of ERISA.

Glossary Appendix

Additional terms may be defined in the Plan Document or the Policy.

Administrator: Either the Claims Administrator or the Plan Administrator.

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

Claim: A written request by a claimant for Plan benefits or for an eligibility determination that contains, at a minimum, the information described in the *Claims Procedures Appendix*.

Claim for an Eligibility Determination: A Claim requesting a determination as to whether a claimant is eligible to be a Participant under the Plan or as to the amount a claimant must contribute towards the cost of coverage.

Claim for Plan Benefits: A Claim requesting that the Plan pay for benefits covered under the Plan.

Claims Administrator: Either the Initial Claims Reviewer or the Appeals Administrator, depending on the context of the sentence in which the term is used.

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

Company: The Dow Chemical Company.

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

Employee: A person who:

a. is employed by a Participating Employer to perform personal services in an employer-employee relationship that is subject to taxation under the Federal Insurance Contributions Act or similar federal statute;

b. receives payment for services performed for the Participating Employer directly from the Company's U.S. payroll or another Participating Employer's U.S. payroll; and

c. if on international assignment, is either a U.S. citizen or Localized in the U.S..

The definition of "Employee" does not include an individual who is determined by the Plan Administrator or the Company to be:

1. a leased employee as defined by Code § 414(n) without regard to the one-year requirement in Code § 414(n)(2), which generally means an individual who provides services to a Participating Employer pursuant to an agreement

between the Participating Employer and another business, such as a leasing organization;

2. an individual retained by the Participating Employer pursuant to a contract or agreement (including a long-term contract or agreement) that specifies that the individual is not eligible to participate in the Plan;

3. an individual whom is classified or treated as an independent contractor; or

4. a self-employed individual, as defined in Code § 401(c)(1)(A), which generally means an individual who has net earnings from self-employment in a trade or business in which the personal services of the individual are a material income-producing factor.

If the Plan Administrator or the Participating Employer determines that an individual is not an "Employee," the individual will not be eligible to participate in the Plan, regardless of whether the determination is subsequently upheld by a court or tax or regulatory authority having jurisdiction over such matters or whether the individual is subsequently treated or classified as an Employee for certain specified purposes. Any change to an individual's status by reason of such reclassification or subsequent treatment will apply prospectively only (i.e., will apply to costs that are incurred and eligible for reimbursement under the terms of the Plan, after the reclassification).

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

Participant: Each Employee or such other individual who, in accordance with Plan, is eligible to participate in the Plan, elects to participate in the Program, and remains eligible for benefits under the Plan.

Participating Employer: The Company or one of its subsidiaries or affiliates that the Company authorizes to participate in the Plan. Notwithstanding anything to the contrary, a "Participating Employer" is only a "Participating Employer" while it is a member of the Company's controlled group of corporations within the meaning of section 414(b) or section 414(c) of the Code. If the entity ceases to be a member of the Company's controlled group of corporations, then the entity ceases to be a "Participating Employer" on the date it is no longer a member of the controlled group of corporations.

Plan: The Dow AgroSciences Long Term Disability Insurance Plan, which is a component plan of The Dow Chemical Company Long Term Disability Program (applicable to those who were fully disabled prior to January 1, 2008), ERISA Plan #506.

Plan Administrator: 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 Company in accordance with the Plan Document.

Plan Document: The plan document for The Dow Chemical Company Long Term Disability Program (applicable to those who were fully disabled prior to January 1, 2008), ERISA Plan #506. The Summary Plan Description is an integral part of the Plan Document.

Plan Year: The 12-consecutive-month period ending each December 31.

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

Summary Plan Description ("SPD"): The summary plan description for the Plan. The SPD is an integral part of the Plan Document.

VPHR: The Vice President of the Company with senior responsibility for human resources.