Group Insurance Benefits

Chemical Weed Control, Inc.

Long Term Disability Insurance

Class 01

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

KANSAS CITY LIFE
INSURANCE COMPANY

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Have a complaint or need help?

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Kansas City Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Group Department at 816-753-7000, extension 8302Toll-free: 1-800-874-5254
Mail: PO Box 219425, Kansas City, MO 64111

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Kansas City Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Group Department al 816-753-7000, extension 8302
Teléfono gratuito: 1-800-874-5254
Dirección postal: PO Box 219425, Kansas City, MO 64111

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

KANSAS CITY LIFE
INSURANCE COMPANY

GROUP LONG TERM DISABILITY INCOME INSURANCE

CERTIFICATE OF COVERAGE

POLICYHOLDER: Chemical Weed Control, Inc. POLICY NUMBER: 25711

POLICYHOLDER EFFECTIVE DATE: January 1, 2022 GOVERNING JURISDICTION: Texas

Kansas City Life Insurance Company (referred to as Kansas City Life) welcomes You as a certificateholder.

This is Your Certificate of Coverage as long as You are eligible for coverage and You become insured. You will want to read it carefully and keep it in a safe place.

We have written Your Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance Law. If You have any questions about any of the terms and provisions, please consult Our claims paying office. We will assist You in any way to help You understand Your benefits.

If the terms and provisions of the Certificate of Coverage (issued to You) are different from the policy (issued to the Policyholder), the policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the Laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the Policyholder's address and end at 12:00 midnight Standard Time at the Policyholder's address.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425.

A. Craig Mason Jr.
Secretary

President, CEO, and Chairman

The policy covers disabilities due to an occupational Sickness or Injury.

The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

CERTIFICATE OF COVERAGE

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SCHEDULE OF BENEFITS

LONG TERM DISABILITY

The Long Term Disability policy provides financial protection for You by paying a portion of Your income while You are disabled. The amount You receive is based on the amount You earned before Your disability began, subject to all policy provisions.

NAME OF EMPLOYER: Chemical Weed Control, Inc.

POLICY NUMBER: 25711

ELIGIBLE CLASS(ES):

Class 01: All Full-Time Employees in Active Employment in the United States with the Employer

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

Persons who are not legal residents or citizens of the United States are not eligible for coverage.

MINIMUM HOURS REQUIREMENT:
40 hours per week

WAITING PERIOD:
As noted in Your Employer's Group Long Term Disability Income Insurance Policy

REHIRE:
If Your employment ends and You are rehired within 12 months, Your previous work while in an eligible class will apply toward the Waiting Period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:
You pay the cost of Your coverage.

WAIVER OF PREMIUM:
We do not require premium payments for Your coverage while You are receiving or are entitled to receive Long Term Disability payments under the policy.

ACCUMULATION OF ELIMINATION PERIOD:
Elimination period: 180 consecutive days.

Accumulation period: 360 consecutive days.

The elimination period and the accumulation period begin on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

MONTHLY BENEFIT:
60.00% of Monthly Earnings to a Maximum Benefit of $6000 per month.

Your benefit may be reduced by any Deductible Sources of Income and Disability Earnings. Some Disabilities may not be covered or may have limited coverage under the policy.

MONTHLY EARNINGS:
"Monthly Earnings" means Your gross monthly income from Your Employer in effect just prior to Your date of disability. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the Monthly Payment.

MAXIMUM PERIOD OF PAYMENT:

Your Age When Disability Begins	**Maximum Period of Payment**
Less than age 61	60 months

Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

REGULAR OCCUPATION PERIOD:

24 months

TOTAL BENEFIT CAP:

If You are eligible to receive payments under the policy in addition to Your Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under the policy) will not exceed 100% of Your Monthly Earnings. However, if You are participating in a Vocational Rehabilitation Plan, the total benefit payable to You on a monthly basis (including all benefits provided under this policy) will not exceed 110% of Your Monthly Earnings.

The above items are only highlights of the policy. For a full description of Your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading Your Certificate of Coverage.

DEFINITIONS

ACTIVE EMPLOYMENT means You are working for Your Employer for earnings that are paid regularly and that You are performing the Material and Substantial Duties of Your Regular Occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the SCHEDULE OF BENEFITS.

To be in Active Employment, Your work site must be:

1) Your Employer's usual place of business; or
2) an alternative work site at the direction of Your Employer, including Your home; or
3) a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that You:

1) regularly visit a Doctor as frequently as medically required according to standard medical practice to effectively treat and manage Your disabling condition(s); and
2) receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Doctor whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3) have the obligation to minimize Your disabling condition including having corrective treatment or minor surgery.

CONTEST means that, if We determine You made a material misrepresentation in Your application for coverage under the policy, We assert in writing that such coverage was therefore never effective. The contest is effective on the date We mail the letter along with a refund of premium.

DEDUCTIBLE SOURCES OF INCOME means income from other sources as listed in the policy which You receive or are eligible to receive while You are disabled. This income will be subtracted from Your Gross Monthly Payment.

DISABILITY EARNINGS means the earnings which You receive while You are disabled and working, plus the earnings You could receive if You were working to Your Maximum Capacity.

DOCTOR means:

1) a person performing tasks that are within the limits of his or her medical license; and
2) a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3) a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
4) a person who is a legally qualified medical practitioner according to the Laws and regulations of the governing jurisdiction.

We will not recognize You or Your family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with You as a Doctor for a claim that You send to Us.

ELIGIBLE SURVIVOR means Your spouse, if living; otherwise, Your children under age 25.

EMPLOYEE means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

EMPLOYER means the Policyholder and includes any division, subsidiary, or affiliated company named in the policy.

ENROLL means You have completed the process of applying for coverage under the policy.

ENROLLMENT FORM means the application You complete and submit to Us to apply for coverage under the policy.

EVIDENCE OF INSURABILITY means a statement of Your medical history that We will use to determine if You are approved for coverage. Evidence of Insurability will be provided at Your own expense.

EVIDENCE OF INSURABILITY FORM means the portion of the Enrollment Form that You complete and submit to Us that contains a statement of Your medical history.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide You with an income within 12 months of Your return to work, that exceeds:

80% of Your Indexed Monthly Earnings if You are working;

60% of Your Indexed Monthly Earnings if You are not working.

GRACE PERIOD means the 31-day period following the premium due date during which premium payment may be made.

GROSS MONTHLY PAYMENT means Your benefit before any reduction for Deductible Sources of Income and Disability Earnings.

HOSPITAL, HEALTH FACILITY, OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing Your disability.

INDEXED MONTHLY EARNINGS means Your Monthly Earnings adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your Indexed Monthly Earnings may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while You are disabled and working and in the determination of Gainful Occupation.

INJURY means a bodily Injury that is the direct result of an Accident and not related to any other cause. The Injury must occur, and disability resulting from the Injury must begin while You are covered under the policy. Injury that occurs before You are covered under the policy will be treated as a Sickness.

INSURED means any person covered under the policy.

INSURED PERSON means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

LAW, PLAN, or ACT means the original enactments of the law, plan, or act and all amendments.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

1) are normally required for the performance of Your Regular Occupation; and

2) cannot be reasonably omitted or modified, except that if You are required to work on average in excess of 40 hours per week, We will consider You able to perform that requirement if You have the capacity to work 40 hours per week.

MAXIMUM BENEFIT means the total monthly benefit amount for which You are insured under the policy subject to all policy provisions.

MAXIMUM CAPACITY means, based on Your restrictions and limitations:

1) during the Regular Occupation Period, the greatest extent of work You are able to do in Your Regular Occupation; and

2) beyond the Regular Occupation Period, the greatest extent of work You are able to do in any occupation for which You are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time We will make payments to You for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY EARNINGS means Your gross monthly income from Your Employer as stated in the SCHEDULE OF BENEFITS.

MONTHLY PAYMENT means Your benefit after any Deductible Sources of Income and Disability Earnings have been subtracted from Your Gross Monthly Payment.

OCCUPATIONAL SICKNESS OR INJURY means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn from 20% through 80% of Your Indexed Monthly Earnings. Ability is based on capacity and not market availability.

PAYABLE CLAIM means a claim for which We are liable under the terms of the policy.

POLICYHOLDER means the Employer to whom the policy is issued and who sponsored the coverage for its Employees.

PRE-EXISTING CONDITION means any condition for which You have done any of the following at any time during the 12 months just prior to Your effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1) received medical treatment or consultation;

2) taken or were prescribed drugs or medicine; or

3) received care or services, including diagnostic measures.

RECURRENT DISABILITY means a disability which is:

1) caused by a worsening in Your condition; and

2) due to the same cause(s) as Your prior disability for which We made a Monthly Payment.

REGULAR OCCUPATION means the occupation You are routinely performing when Your disability begins. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

REGULAR OCCUPATION PERIOD is the period of time shown in the SCHEDULE OF BENEFITS that begins after the elimination period.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to Employees and are not funded entirely by Employee contributions. Retirement plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

SALARY CONTINUATION or ACCUMULATED SICK LEAVE means continued payments to You by Your Employer of all or part of Your Monthly Earnings, after You become disabled as defined by the policy. This continued payment must be part of an established plan maintained by Your Employer, and includes Salary Continuation, Accumulated Sick Leave or any similar Employer sponsored paid time off plan.

SICKNESS means illness, disease, or physical condition. Disability resulting from the Sickness must begin while You are covered under the policy.

TEMPORARY LAYOFF or LEAVE OF ABSENCE means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time or any period of disability is not considered a Temporary Layoff or Leave of Absence.

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by Us, prepares in accordance with the Vocational Rehabilitation Services provision of the policy.

WAITING PERIOD means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that You must be in Active Employment in an eligible class before You are eligible for coverage under the policy.

WE, **US**, and **OUR** means Kansas City Life Insurance Company.

YOU and **YOUR** means a person who is eligible for coverage under the policy.

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by Us and may include attachments. It tells You:

1) the coverage to which You may be entitled;
2) to whom We will make a payment; and
3) the limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If You are working for Your Employer in an eligible class, the date You are eligible for coverage is the later of:

1) the policy effective date; or
2) the day after You complete Your Waiting Period.

WHEN COVERAGE BEGINS

When Your Employer pays 100% of the cost of Your coverage under the policy, You will be covered at 12:01 a.m. Standard Time at Your Employer's address on the date You are eligible for coverage.

When You and Your Employer share the cost of Your coverage under the policy or when You pay 100% of the cost yourself, You will be covered at 12:01 a.m. Standard Time at the Policyholder's address on the latest of:

1) the date You are eligible for coverage, if You Enroll for insurance on or before that date;
2) the first day of the month following the date You Enroll for insurance, if You Enroll within 31 days after the date You become eligible for coverage; or
3) the first day of the month following the date We approve Your Enrollment Form, if Evidence of Insurability is required.

In order for Your coverage to begin, You must be in Active Employment. Your coverage is subject to payment of premium.

CHANGES TO YOUR COVERAGE

Once Your coverage begins, any increased or additional coverage will take effect immediately if You are in Active Employment or if You are on a covered Temporary Layoff or Leave of Absence. If You are not in Active Employment due to Injury or Sickness, any increased or additional coverage will begin on the date You return to Active Employment.

Any decrease in coverage will take effect immediately but will not affect a Payable Claim that occurs prior to the decrease.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of Insurability is required if:

1) You are a late applicant, which means You Enroll for coverage more than 31 days after the date You are eligible for coverage;
2) You voluntarily canceled Your coverage and are reapplying.

An Evidence of Insurability Form can be obtained from Your Employer.

IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If You are on a Leave of Absence, and if premium is paid, Your coverage may be continued beyond the date You are no longer in Active Employment, limited to the time periods described below.

If You are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 ("FMLA") or applicable state family and medical leave Law ("State FML"), and Your Employer's Human Resource Policy provides for continuation of disability coverage during a FMLA or State FML Leave of Absence, Your coverage will be continued until the end of the later of:

1) the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or

2) the leave period permitted by applicable state Law.

If You are on a Leave of Absence other than a FMLA or State FML Leave of Absence, and if premium is paid, Your coverage will be continued through the end of the month that immediately follows the month in which Your Leave of Absence begins.

If You are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state Law, Your coverage may be continued until the end of the later of:

1) the length of time the coverage may be continued under the Certificate of Coverage for a FMLA or State FML Leave of Absence; or

2) the length of time the coverage may be continued under the Certificate of Coverage for a Leave of Absence other than a FMLA or State FML Leave of Absence.

If Your Employer has approved more than one type of Leave of Absence for You during any one period that You are not in Active Employment, We will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under the policy.

If Your coverage is not continued during a FMLA or State FML Leave of Absence, and You return to Active Employment immediately following the end of Your FMLA or State FML Leave of Absence, Your coverage will be reinstated. We will not apply a new Waiting Period, require Evidence of Insurability, or apply a new Pre-Existing Condition limitation.

If Your coverage is not continued during a Leave of Absence for active military service, and You return to Active Employment, Your coverage may be reinstated in accordance with USERRA and applicable state Law.

In no event will Your coverage under the policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

IF YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO A TEMPORARY LAYOFF

If You are not in Active Employment due to a Temporary Layoff, and if premium is paid, You will be covered through the end of the month that immediately follows the month in which Your Temporary Layoff begins.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of:

1) the date the policy is canceled;

2) the date You are no longer in an eligible class;

3) the date Your eligible class is no longer covered;

4) the end of the Grace Period after a premium due date if premium is not paid; or

5) the last day You are in Active Employment except as provided under a covered Leave of Absence or Temporary Layoff.

We will provide coverage for a Payable Claim that occurs while You are covered under the policy.

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding Your claim 60 days after proof of claim has been given to Us, and up to three years from the time proof of claim is required, unless otherwise provided under federal Law.

STATEMENTS MADE IN AN APPLICATION FOR COVERAGE

We consider any statements the Policyholder and You make in an application representations and not warranties. No statements made by You will be used to reduce or deny any claim or to cancel Your coverage unless:

1) the statement is in writing and is signed by You; and

2) a copy of that statement is given to You or Your beneficiary.

TIME LIMIT ON CERTAIN DEFENSES

Except in the case of fraud, no statement made by You relating to Your insurability will be used to Contest the insurance for which the statement was made after the coverage has been in force for two years.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition,

not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

CLERICAL ERROR

Clerical error or omission by Us or the Policyholder will not:

1) prevent You from receiving coverage, if You are entitled to coverage under the terms of the policy; or

2) cause coverage to begin or continue for You when the coverage would not otherwise be effective.

If the Policyholder gives Us information about You that is incorrect, We will:

1) use the facts to decide whether You have coverage under the policy and in what amounts; and

2) make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums applicable to You are based on age and You have misstated Your age, there will be a fair adjustment of premiums based on Your true age. If the benefits applicable to You are based on age and You have misstated Your age, there will be an adjustment of said benefits based on Your true age. We may require satisfactory proof of Your age before paying any claim.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the Policyholder acts on their own behalf or as Your agent. Under no circumstances will the Policyholder be deemed Our agent.

LONG TERM DISABILITY BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1) You are unable to perform all the Material and Substantial Duties of Your Regular Occupation; and

2) You have a 20% or more loss in Your Indexed Monthly Earnings.

After the Regular Occupation Period, You are considered disabled when We review Your claim and determine that, due to Your Sickness or Injury, You are unable to perform the duties of any Gainful Occupation for which You are reasonably qualified based on Your training, education and experience.

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

You must be under the Appropriate Care of a Doctor in order to be considered disabled.

We may require You to be examined by one or more Doctors, other medical practitioners, or vocational experts of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require You to be interviewed by Our authorized representative. Your failure to comply with this request may result in denial or termination of benefits.

ACCUMULATION OF ELIMINATION PERIOD

You must be continuously disabled through Your elimination period. Your elimination period is as stated in the SCHEDULE OF BENEFITS and is the period of continuous disability You must satisfy before You are eligible to receive benefits under the policy.

If You return to work while satisfying Your elimination period, You may satisfy Your elimination period within the accumulation period. The accumulation period is as stated in the SCHEDULE OF BENEFITS.

The days that You are not disabled will not count toward Your elimination period.

If You do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

The elimination period and the accumulation period begin on the first day of Your disability.

Benefits for a Payable Claim begin the day after the elimination period is completed.

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If You are working while You are disabled, the days You are disabled will count toward Your elimination period.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when We approve Your claim, providing the elimination period has been met and You are disabled. We will send You a Monthly Payment at the end of each month for any period for which We are liable.

After the elimination period, if You are disabled for less than 1 month, We will send You 1/30th of Your Monthly Payment for each day of Your disability.

AMOUNT OF PAYMENT

A. IF YOU ARE DISABLED AND NOT WORKING, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS

We will follow this process to figure Your payment:

1) Multiply Your Monthly Earnings by 60.00%.

2) The Maximum Benefit is $6000 per month.

3) Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Monthly Payment.

4) Subtract from Your Gross Monthly Payment any Deductible Sources of Income.

The amount figured in Item 4 is Your Monthly Payment.

B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR INDEXED MONTHLY EARNINGS

During the first 12 months of payments, the sum of Your Gross Monthly Payment plus Disability Earnings may be less than or equal to, but not more than, 100% of Your Indexed Monthly Earnings. If the sum exceeds 100% of Your Indexed Monthly Earnings, We will reduce Your payment under the policy by the excess amount.

To determine whether the sum of Your Gross Monthly Payment plus Disability Earnings is less than or equal to or exceeds 100% of Your Indexed Monthly Earnings, We will follow this process:

1) Multiply Your Monthly Earnings by 60.00%.
2) The Maximum Benefit is $6000 per month.
3) Compare the answer from Item 1 with the Maximum Benefit. The lesser of these two amounts is Your Gross Monthly Payment.
4) Add Your Disability Earnings to Your Gross Monthly Payment.

If the answer in Item 4 above is less than or equal to 100% of Your Indexed Monthly Earnings, Your Monthly Payment will be Your Gross Monthly Payment minus any Deductible Sources of Income.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will follow this process to figure Your Monthly Payment:

a. Add Your Disability Earnings to Your Gross Monthly Payment.
b. From the answer in Item a, subtract Your Indexed Monthly Earnings. If the result is zero or less, record Your answer as zero.
c. From Your Gross Monthly Payment, subtract the answer in Item b and any Deductible Sources of Income.

The amount figured in Item c is Your Monthly Payment.

After 12 months of Monthly Payments, You will receive payments based on the percentage of income You are losing due to Your Disability. We will follow this process to determine Your Monthly Payment:

1) Subtract Your Disability Earnings from Your Indexed Monthly Earnings.
2) Divide the answer in Item 1 by Your Indexed Monthly Earnings. The result is Your percentage of lost earnings.
3) From Your Gross Monthly Payment, subtract any Deductible Sources of Income.
4) Multiply the answer in Item 2 by the answer in Item 3.

The answer in Item 4 is Your Monthly Payment.

C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR INDEXED MONTHLY EARNINGS

If You are working and Your Disability Earnings are more than 80% of Your Indexed Monthly Earnings, no benefit will be payable.

We may require You to send proof of Your monthly Disability Earnings each month. We will adjust Your payment based on Your monthly Disability Earnings.

As part of Your proof of Disability Earnings, We can require that You send Us appropriate financial records that We believe are necessary to substantiate Your income.

After the elimination period, if You are disabled for less than one month, We will send You 1/30th of Your Monthly Payment for each day of disability.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If Your Disability Earnings routinely fluctuate widely from month to month, We may average Your Disability Earnings over the most recent three months to determine if Your claim should continue.

If We average Your Disability Earnings, We will not terminate Your claim unless the average of Your Disability Earnings from the last three months exceeds 80% of Your Indexed Monthly Earnings.

We will not pay You for any month during which Your Disability Earnings exceed the amount allowable under the policy. In no event will benefits be paid beyond the Maximum Period of Payment.

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If You are eligible to receive benefits under the policy in addition to the Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under the policy) will not exceed 100% of Your Monthly Earnings. However, if You are participating in a Vocational Rehabilitation Plan, the total benefit payable to You on a monthly basis (including all benefits provided under this policy) will not exceed 110% of Your Monthly Earnings.

DEDUCTIBLE SOURCES OF INCOME

The following are Deductible Sources of Income:

1) The amount that You receive, or are eligible to receive, as disability income payments under any:
   a. state compulsory benefit Act or Law;
   b. individual disability income plans which are paid for by the Policyholder and purchased on or after the effective date of this policy;
   c. automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable;
   d. military disability benefit plan;
   e. governmental retirement system as a result of Your job with Your Employer; or
   f. other group insurance policy.
2) The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
3) The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
4) The amount You receive under any Salary Continuation or Accumulated Sick Leave plan.
5) The amount that You:
   a. receive as disability payments under Your Employer's Retirement Plan;
   b. voluntarily elect to receive as retirement payments under Your Employer's Retirement Plan; or
   c. are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in Your Employer's Retirement Plan.

   Disability payments under a Retirement Plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are paid based on Your Employer's contribution to the Retirement Plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider the Employer and Employee contributions to be distributed simultaneously throughout Your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible Retirement Plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
6) The amount that You, Your spouse, and Your children receive, or are eligible to receive, as disability payments because of Your disability under:
   a. the United States Social Security Act;
   b. the Canada Pension Plan;
   c. the Quebec Pension Plan; or
   d. any similar Plan or Act.
7) The amount that You receive as retirement payments or the amount Your spouse and Your children receive as retirement payments because You are receiving retirement payments under:
   a. the United States Social Security Act;
   b. the Canada Pension Plan;

c. the Quebec Pension Plan; or

d. any similar Plan or Act.

8) The amount You earn or receive from any form of employment.

9) The amount You receive from any unemployment compensation Law.

10) The amount that You receive, or are eligible to receive, under:

a. a workers' compensation Law;

b. an occupational disease Law; or

c. any other Act or Law with similar intent.

With the exception of retirement payments, We will only subtract Deductible Sources of Income which are payable as a result of the same disability.

We will not reduce Your payment by Your Social Security retirement income if Your disability begins after age 65 and You were already receiving Social Security retirement payments.

IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income You earn from any form of employment, once We have subtracted any Deductible Source of Income from Your Gross Monthly Payment, We will not further reduce Your payment due to a cost of living increase from that source.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

When We determine that You may qualify for benefits for which You are eligible in the Deductible Sources of Income section, We will estimate Your entitlement to these benefits. We can reduce Your benefit under the policy by the estimated amounts if such benefits:

1) have not been awarded or denied; or

2) have been denied and the denial is being appealed.

Your Gross Monthly Payment will NOT be reduced by the estimated amount if You:

1) apply for the disability payments for which You are eligible in the Deductible Sources of Income section and appeal Your denial to all administrative levels We determine are necessary; and

2) sign Our form. This form states that You promise to pay Us any overpayment caused by an award and We shall be entitled to impose a constructive trust on any such award.

If Your Gross Monthly Payment has been reduced by an estimated amount, Your Gross Monthly Payment will be adjusted when We receive proof:

1) of the amount awarded; or

2) that benefits have been denied and all appeals We determine are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to You.

If You receive a lump sum payment from any Deductible Source of Income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over Your expected lifetime as determined by Us.

NON-DEDUCTIBLE SOURCES OF INCOME

We will not subtract from Your Gross Monthly Payment income You receive from, the following:

1) 401(k) plans;

2) profit sharing plans;

3) thrift plans;

4) tax-sheltered annuities;

5) stock ownership plans;

6) credit disability insurance;

7) non-qualified plans of deferred compensation;

8) pension plans for partners;

9) military pension plans;

10) franchise disability income plans;

11) individual disability plans paid for by the Insured Person;

12) a retirement plan from another employer;

13) individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a Payable Claim is the greater of:

1) $100; or

2) 10% of Your Gross Monthly Payment.

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send You a payment each month up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS will be paid during a continuous period of disability, and will be based on Your age at disability.

WHEN PAYMENTS END

We will stop sending You payments and Your claim will end on the earliest of the following:

1) the end of the Maximum Period of Payment;

2) the date You are no longer disabled under the terms of the policy;

3) the date You fail to submit proof of continuing disability;

4) the date You die;

5) during the Regular Occupation Period when You are able to return to work in Your Regular Occupation on a Part-Time Basis but You do not;

6) after the Regular Occupation Period, when You are able to work in any Gainful Occupation on a Part-Time Basis but You do not;

7) the date Your Disability Earnings exceed 80% of Your Indexed Monthly Earnings; or

8) after 12 months of payments if You are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when You have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay a benefit for any period of disability during which You are incarcerated.

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities caused by, contributed to by, or resulting from Your:

1) loss of professional license, occupational license, or certification;

2) participation in a felony;

3) intentionally self-inflicted injuries;

4) attempted suicide, regardless of mental capacity;

5) participation in a war, declared or undeclared, or any act of war;

6) active military duty;

7) active participation in a riot;

8) engaging in any illegal or fraudulent occupation, work, or employment;

9) commission of a crime for which You have been convicted;

10) elective surgery except when required for Your Appropriate Care as a result of Your Injury or Sickness; or

11) traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if Your disability begins in the first 12 months following the effective date of Your coverage and Your disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which You received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the 12 months just prior to Your effective date of coverage.

If there is an increase in the Maximum Benefit after the Policy Effective Date, this PRE-EXISTING CONDITION LIMITATION provision will apply to the amount of the increase in the Maximum Benefit, as of the effective date of the increase.

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The lifetime cumulative Maximum Period of Payment for all disabilities due to Mental Illness, alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

1) are not continuous; and/or

2) are not related.

We will continue to send You payments beyond the 24-month period if You meet one or both of these conditions:

1) If You are confined to a Hospital, Health Facility or Institution at the end of the 24-month period, We will continue to send You payment(s) during Your confinement.

   If You are still disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

   If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2) In addition to Item 1, if You continue to be disabled after the 24-month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.

We will not apply the Mental Illness limitation to a disability due to dementia if it is a result of:

1) stroke;

2) trauma;

3) viral infection; or

4) Alzheimer's disease.

RECURRENT DISABILITY

If You have a Recurrent Disability, and after Your prior disability ended, You returned to work for Your Employer for 6 months or less, We will treat Your disability as part of Your prior claim and You do not have to complete another elimination period.

Your Monthly Payment will be based on Your Monthly Earnings as of the date of Your initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as Your prior claim.

Your disability will be treated as a new claim if Your current disability:

1) is unrelated to Your prior disability; or

2) after Your prior disability ended, You returned to work for Your Employer for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and You will be required to satisfy a new elimination period.

If Our policy terminates and You become eligible for payments under any other group disability plan that replaces Our policy, You will not be eligible for payments under Our policy.

BENEFITS IF YOU DIE - SURVIVOR BENEFIT

When We receive proof that You have died, We will pay Your Eligible Survivor a lump sum benefit equal to 3 times Your last Monthly Payment if, on the date of Your death:

1) Your disability had continued for 180 or more consecutive days; and

2) You were receiving or were eligible to receive payments under the policy.

If You have no Eligible Survivors, payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, We will first apply the Survivor Benefit to recover any overpayment that may exist on Your claim.

ADVANCED SURVIVOR BENEFIT

You may receive an Advanced Survivor Benefit prior to Your death if You have been diagnosed with a Terminal Illness.

We will pay You a lump sum amount equal to 3 times Your last Monthly Payment if:

1) Your disability had continued for 180 or more consecutive days, and

2) You have been diagnosed with a Terminal Illness.

However, We will first apply the Advanced Survivor Benefit to recover any overpayment which may exist on Your claim.

Your right to exercise this option and receive payment is subject to the following:

1) You must make this election in writing to Us; and

2) Your Doctor must certify in writing that You have a Terminal Illness.

This benefit is available to You on a voluntary basis and will be payable one time only under this policy.

If You receive the Advanced Survivor Benefit prior to Your death, the 3-month Survivor Benefit will not be payable upon Your death.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist You in returning to work to the extent of Your ability. We will review Your disability claim to determine whether You are eligible for these services, at Our sole discretion. In order to be eligible for vocational rehabilitation services and benefits, You must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help You return to gainful employment. As Your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of Your eligibility for these services.

If We determine that vocational rehabilitation services are appropriate, We will provide You with a written Vocational Rehabilitation Plan developed specifically for You.

The Vocational Rehabilitation Plan may include at Our sole discretion, but is not limited to, the following services:

1) coordination with Your Employer to assist You to return to work;

2) evaluation of adaptive equipment or job accommodations to allow You to work;

3) evaluation of possible workplace modifications which might allow You to return to work in Your Regular Occupation or another job or occupation;

4) vocational evaluation to determine how Your disability may impact Your employment options;

5) job placement services, including resume preparation services and training in job-seeking skills;

6) alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance Your ability to work.

VOCATIONAL REHABILITATION BENEFIT

If You are receiving Monthly Payments under the policy, and You are participating in a Vocational Rehabilitation Plan, You may be eligible for an additional Vocational Rehabilitation Benefit. We will pay an additional benefit of 5% of Your Gross Monthly Payment to a maximum of $500 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

WHEN VOCATIONAL REHABILITATION BENEFITS END

Vocational Rehabilitation Benefits will end on the earliest of the following dates:

1) the date We determine that You are no longer eligible to participate in a Vocational Rehabilitation Plan;
2) the date You are no longer participating in a Vocational Rehabilitation Plan; or
3) any other date on which Monthly Payments would stop in accordance with the policy.

WORKPLACE MODIFICATION BENEFIT

If You are disabled and are receiving a payment from Us, an additional Workplace Modification Benefit may be payable to Your Employer for Your benefit. We may reimburse Your Employer for up to 100% of the reasonable costs Your Employer incurs through modifications to the workplace to accommodate Your return to work, and to assist You in remaining at work.

The amount We may pay will not exceed the lesser of:

1) 2 times Your last Monthly Payment; or
2) $2000.

To qualify for this reimbursement, You must:

1) be disabled according to the terms of the policy; and
2) have the reasonable expectation of returning to Active Employment and remaining in Active Employment with the assistance of the proposed workplace modification.

Your Employer must give Us a written proposal of the proposed workplace modification. This proposal must include:

1) input from the Employer, You and Your Doctor;
2) the purpose of the proposed workplace modification;
3) the expected completion date of the workplace modification; and
4) the cost of the workplace modification.

We will reimburse the costs of the workplace modification when We:

1) approve the proposal in writing;
2) receive proof from Your Employer that the workplace modification is complete; and
3) receive proof of the costs incurred by Your Employer for the workplace modification.

This benefit is available on a one time basis.

LONG TERM DISABILITY CLAIM INFORMATION

NOTICE OF CLAIM

We encourage You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to Us within 30 days after the date Your disability begins. The notice may be given to Us at Our home office or to Our authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

The claim form is available from the Policyholder, or You can request a claim form from Us. If You do not receive the form from Us within 15 days of Your request, send Us written proof of claim without waiting for the form.

You must notify Us immediately when You return to work in any capacity.

FILING A CLAIM

You and Your Employer must fill out Your own sections of the claim form and then give it to Your attending Doctor. Your Doctor should fill out his or her section of the form and send it directly to Us.

PROOF OF YOUR CLAIM

You must send Us written proof of Your claim no later than 90 days after Your elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any Payable Claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible.

Your proof of claim, provided at Your expense, must show:

1) that You are under the Appropriate Care of a Doctor;
2) the date Your disability began;
3) the cause of Your disability;
4) the appropriate documentation of Your earnings and Your activities;
5) the extent of Your disability, including restrictions and limitations preventing You from performing Your Regular Occupation;
6) the name and address of any Hospital, Health Facility or Institution where You received treatment, including all attending Doctors; and
7) documentation of prior disability coverage, if applicable.

In some cases, You will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of Your proof of claim, or proof of continuing disability. We will deny Your claim, or stop sending You payments, if the appropriate information is not submitted within 45 days of the request.

You or Your Employer must notify Us immediately when You return to work in any capacity.

MAKING PAYMENTS

Once Your claim has been approved, but no later than 60 days after such proof is received, We will send You a payment at the end of each month for any period for which We are liable. Any balance remaining unpaid at the termination of such period of disability will be paid immediately upon receipt of such proof.

OVERPAID CLAIMS

We have the right to recover any overpayments due to:

1) fraud;
2) any administrative error We make in processing a claim; or
3) Your receipt of Deductible Sources of Income.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount We paid You. However, We reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

The Following Important Notice is Provided by Your Employer for Your Information Only.

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your certificate are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

1. Plan Name

Group Plan for employees of Chemical Weed Control, Inc.

2. Plan Number

3. Employer/Plan Sponsor

Chemical Weed Control, Inc.
7892 Wickson Ridge Drive
Bryan, TX 77808

4. Employer Identification Number

752140016

5. Type of Plan

Welfare Benefit Plan providing Group Long Term Disability benefits.

6. Plan Administrator

Chemical Weed Control, Inc.
7892 Wickson Ridge Drive
Bryan, TX 77808

7. Agent for Service of Legal Process

For the Plan:

Chemical Weed Control, Inc.
7892 Wickson Ridge Drive
Bryan, TX 77808

For the Policy:

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64111

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8. Sources of Contributions -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

9. Type of Administration -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10. The Plan and its records are kept on a Policy Year basis.

11. Labor Organizations

None

12. Names and Addresses of Trustees

Chemical Weed Control, Inc.
7892 Wickson Ridge Drive
Bryan, TX 77808

13. Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits:

   a) 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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

   c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Continue Group Health Plan Coverage:

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuous coverage rights.

3) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4) Enforce Your Rights:

If your claim for a welfare benefit 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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.

5) Assistance with Your Questions:

If you have any questions about your 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 office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claim Procedures for Disability Income Insurance Plans

1) Claims for Benefits:

If you would like to present a claim for benefits for yourself or your insured dependents, you should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) should be completed by (1) you, (2) the Employer or Administrator and (3) the Attending Physician or hospital.

Following completion, the claim form(s) must be forwarded to the individual authorized to evaluate claims (Administrator or Insurance Company's Claim Representative). The individual authorized to evaluate claims will determine if benefits are payable and, if due, issue payment(s) to you.

The Insurance Company will make a decision no more than 45 days after receipt of your claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request.

The written decision will include: 1) specific reasons for the decision, 2) specific references to the plan provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and, 6) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, a copy of the rule, guideline, protocol, or other similar criterion will be provided to the claimant with the denial letter free of charge. 7) an explanation of language services for claimants living in counties where 10% or more of the population speaks a non-English language.

1) Appealing Denial of Claims:

On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You may:

a) request a review upon written application within 180 days of the claim denial;

b) request, free of charge, copies of all documents, records, and other information relevant to your claim; and

c) submit written comments, documents, records and other information relating to your claim.

The Insurance Company will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.