Group Insurance Benefits

Chemical Weed Control, Inc.

Short Term Disability Insurance

Class 01

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 64121-9425

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 64121-9425

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 SHORT 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. When making a benefit determination under the policy, We have discretionary authority within the reasonable limits established by the law to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

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 does not cover 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

SHORT TERM DISABILITY

The Short 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:

Class 01: 40 hours per week

WAITING PERIOD:

As noted in Your Employer's Group Short 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:

Your Employer pays the cost of Your coverage.

ELIMINATION PERIOD:

0 consecutive days for disability due to Injury.

7 consecutive days for disability due to Sickness.

The elimination period begins on the first day of Your disability.

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

WEEKLY BENEFIT:

60.00% of Weekly Earnings to a Maximum Benefit of $1500 per week.

Your benefit may be reduced by any Deductible Sources of Income and Disability Earnings. Some disabilities may not be covered under the policy.

WEEKLY EARNINGS:

"Weekly Earnings" means Your gross weekly 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 weekly amount for the purpose of calculating the Weekly Payment.

MAXIMUM PERIOD OF PAYMENT: 26 weeks

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 Weekly 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.

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.

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

GROSS WEEKLY 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.

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 weekly benefit amount for which You are Insured under the policy subject to all policy provisions.

MAXIMUM CAPACITY means, based on Your restrictions and limitations, the greatest extent of work You are able to do in Your Regular Occupation.

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

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 Weekly 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.

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 Weekly 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.

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 Weekly 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.

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.

WEEKLY EARNINGS means Your gross weekly income from Your Employer as stated in the SCHEDULE OF BENEFITS.

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

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.

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.

No claim for disability with respect to which the claim is made, shall be reduced or denied on the grounds 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.

SHORT 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 Weekly Earnings.

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.

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.

The elimination period begins on the first day of Your disability.

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

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 Weekly Payment at the end of each week for any period for which We are liable.

After the elimination period, if You are disabled for less than 1 week, We will send You $1/7^{th}$ of Your Weekly 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 WEEKLY EARNINGS

We will follow this process to figure Your payment:

1) Multiply Your Weekly Earnings by 60.00%.

2) The Maximum Benefit is $1500 per week.

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

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

The amount figured in Item 4 is Your Weekly 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 WEEKLY EARNINGS

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 Weekly Payment:

1) Subtract Your Disability Earnings from Your Weekly Earnings.

2) Divide the answer in Item 1 by Your Weekly Earnings. The result is Your percentage of lost earnings.

3) From Your Gross Weekly 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 Weekly Payment.

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

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

If You are able to perform all the Material and Substantial Duties of Your Regular Occupation and Your Disability Earnings are more than 80% of Your Weekly Earnings, no benefit will be payable.

We may require You to send proof of Your weekly Disability Earnings each week. We will adjust Your payment based on Your weekly 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 1 week, We will send You 1/7th of Your Weekly Payment for each day of disability.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If Your Disability Earnings routinely fluctuate widely from week to week, We may average Your Disability Earnings over the most recent three weeks 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 weeks exceeds 80% of Your Weekly Earnings.

We will not pay You for any week 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.

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.

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 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 Weekly 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 Weekly Payment has been reduced by an estimated amount, Your Gross Weekly 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 weekly 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 weekly 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 Weekly 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 week for a Payable Claim is $25.

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send You a payment each week up to the Maximum Period of Payment. Your Maximum Period of Payment is stated in the SCHEDULE OF BENEFITS and will be paid during a continuous period of 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) when You are able to return to work in Your Regular Occupation on a Part-Time Basis but You do not; or
6) the date Your Disability Earnings exceed 80% of Your Weekly Earnings.

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

12) Occupational Sickness or Injury.

RECURRENT DISABILITY

If You have a Recurrent Disability, and after Your prior disability ended, You returned to work for Your Employer for 14 days or less, We will treat Your disability as part of Your prior claim and You do not have to complete another elimination period.

Your Weekly Payment will be based on Your Weekly 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 14 consecutive days.

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.

SHORT 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. You must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

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 week for any period for which We are liable.

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 Short 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 64121-9425

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.