

FARM CREDIT FOUNDATIONS

MEDICAL PLAN

WRAP AROUND PLAN DOCUMENT

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FARM CREDIT FOUNDATIONS MEDICAL PLAN

PREAMBLE

The Farm Credit Foundations Medical Plan (“Medical Plan”) is sponsored and maintained by AgriBank, FCB (“AgriBank”) and U.S. AgBank, FCB (“U.S. AgBank”) for the benefit of the eligible employees of each Bank, their affiliated associations, and other employers within the federal Farm Credit System, including Northwest Farm Credit Services, who are parties to the Farm Credit System Administrative Agreement Regarding Employee Benefit Plans (“Administrative Agreement”).

Participation in this Medical Plan is limited to employers who are members of the federal Farm Credit System. The Farm Credit System is defined in the Farm Credit Act of 1971, as amended (12 U.S.C. § 2001 *et seq.*), to include “the Farm Credit Banks, the Federal land bank associations, the production credit associations, the banks for cooperatives, and such other institutions as may be made a part of the System, all of which shall be chartered by and subject to regulation by the Farm Credit Administration.” 12 U.S.C. § 2002(a).

Under the provisions of the Farm Credit Act of 1971, AgriBank and U.S. AgBank are defined and declared to be “instrumentalities of the United States.” 12 U.S.C. § 2011(a). Those participating employers that are Production Credit Associations and/or Federal Land Bank Associations are also defined and declared by statute to be “federally chartered instrumentalities of the United States.” 12 U.S.C. §§ 2071(a), 2091(a). Those participating employers that are Agricultural Credit Associations and Federal Land Credit Associations are defined and declared to be “instrumentalities of the United States” in the charters issued to them by the Farm Credit Administration.

For this reason, the Medical Plan is intended to be a “governmental plan” as that term is defined in Code § 414(d). As a “governmental plan,” the Medical Plan is not subject to Title I of the Employee Retirement Income Security Act of 1974 (“ERISA”). In addition, the Medical Plan is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), although it voluntarily offers continuation coverage similar to that found in COBRA as set forth later in this Medical Plan.

Because of the close relationship that exists between the employers in the Medical Plan under the provisions of the Farm Credit Act and the terms of their respective charters and because of their status as “instrumentalities of the United States,” the Medical Plan, consistent with prior historical practice, is designed and intended to be a single employer plan.

ARTICLE I INTRODUCTION

Section 1.01 Purpose of Medical Plan. The purpose of this Medical Plan is to provide Eligible Employees and their eligible Dependents with medical benefits.

Section 1.02 Health Plan Status. The Employer intends that this Medical Plan qualify as a health plan within the meaning of Code § 105(e) and that the benefits payable under this Medical Plan be eligible for exclusion from gross income under Code § 105(b).

Section 1.03 Single Employer Plan Status. In light of this Medical Plan's status as a "governmental plan," it is the intent of the Employer that this Medical Plan be considered a single employer plan.

Section 1.04 Exclusive Benefit. It is intended that the Medical Plan terms, including those related to coverage and benefits, be legally enforceable and that the Medical Plan be maintained for the exclusive benefit of Eligible Employees and their eligible Dependents.

Section 1.05 Effect on Prior Plans. Prior to January 1, 2007, AgriBank and its affiliated associations, U.S. AgBank and its affiliated associations, Northwest Farm Credit Services, and other employers within the federal Farm Credit System who are parties to the Administrative Agreement maintained certain welfare benefit plans on a separate basis. Pursuant to the Administrative Agreement, effective January 1, 2007, AgriBank and its affiliated associations, U.S. AgBank and its affiliated associations, and other employers within the federal Farm Credit System have agreed to consolidate certain employee benefit plans previously sponsored separately. Effective January 1, 2007, this Medical Plan amends and restates the separate medical benefit plans that were previously sponsored by AgriBank and its affiliated associations, and U.S. AgBank and its affiliated associations, and other employers within the federal Farm Credit System. As part of this amendment and restatement, the name of the plan is changed to the Farm Credit Foundations Medical Plan.

Section 1.06 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Medical Plan. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

Section 1.07 Funding Policy and Method. The medical benefits under this Medical Plan are funded by the Employer. The cost of providing these medical benefits is paid for by Employer and Employee contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under this Medical Plan, but shall have no obligation to do so. Salary reduction amounts paid under the Medical Plan are made periodically during the Plan Year based upon the amounts (if any) by which the cost of the selected Medical Plan benefits exceeds the amount of Employer contributions pursuant to the Farm Credit Foundations Flexible Benefits Plan.

Section 1.08 Effective Date. The effective date of this Medical Plan as amended and restated is January 1, 2007; provided, however, that if this Medical Plan is subsequently amended, such new or amended provisions shall be effective on a later date as provided in the Plan Sponsor Committee minutes adopting such new or amended provisions.

Section 1.09 Required Forms. The Plan Administrator may require the completion and submission of any form required pursuant to this Medical Plan (e.g., enrollment forms) in electronic form through the use of the internet, an intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

ARTICLE II DEFINITIONS

This Medical Plan contains various words and phrases that are defined in either this Article II or in the definitions section of the applicable Benefit Schedule. Where the defined meaning is intended, the term is capitalized in both the Wrap Around Plan Document and the applicable Benefit Schedule.

Section 2.01 “**Administrative Agreement**” means the Farm Credit System Administrative Agreement Regarding Employee Benefit Plans, as amended from time to time.

Section 2.02 “**Benefit Description**” means the Benefit Description for the Farm Credit Foundations Medical Plan, which is attached to this Wrap Around Plan Document and is incorporated by reference.

Section 2.03 “**Benefit Schedules**” means the various Benefit Schedules for the Farm Credit Foundations Medical Plan, which are incorporated by reference and made a part of the Benefit Description. Any definitions in the Benefit Schedules are incorporated by reference in this Wrap Around Plan Document.

Section 2.04 “**Calendar Year**” means the period of twelve (12) consecutive months from January 1 through December 31.

Section 2.05 “**Certificate of Creditable Coverage**” means a certificate disclosing information relating to your creditable coverage under a health care benefit program for purposes of reducing any preexisting condition exclusion imposed by any group health plan coverage.

Section 2.06 “**Child**” or “**Children**” when either of such terms is used in the definition of Dependent, includes an Employee’s or Disabled Person’s natural children, adopted children, stepchildren, foster children, or children under the Employee’s or Disabled Person’s legal guardianship by court order.

Section 2.07 “**Claimant**” means a Participant who files a Claim for benefits pursuant to this Medical Plan.

Section 2.08 “**Claims Administrator**” means the company or companies (if any) which the Employer has retained, on an insured or contract administration basis, to assist in making determinations whether to grant or deny Claims for benefits under this Medical Plan. The identity of the Claims Administrator(s) is set forth in Articles IX and X of this Medical Plan.

Section 2.09 “**Code**” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.10 “**Dependent,**” unless otherwise set forth in the policy of a fully insured benefit option set forth on the Benefit Description, means:

- (A) An Employee's or Disabled Person's spouse, but only if the spouse is not divorced or legally separated from the Employee or Disabled Person; and
- (B) An Employee's or Disabled Person's Children if such Children:
 - (1) Are under age 19; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Employee or Disabled Person for financial support; and
 - (4) Are either (a) living with the Employee or Disabled Person in a normal parent-child relationship, or (b) entitled to the provision of medical coverage under this Medical Plan by virtue of a court order under which the Employee or Disabled Person is legally responsible to provide medical coverage.
- (C) An Employee's or Disabled Person's Children if such Children:
 - (1) Are between the ages of 19 and 25; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Employee or Disabled Person for financial support; and
 - (4) Are enrolled in and attending an accredited educational or vocational institution with full-time student status.
- (D) An Employee's or Disabled Person's Children if such Children:
 - (1) Are over age 19; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Employee or Disabled Person as their primary source of financial support at the time the Child would otherwise cease to be eligible because of age; and
 - (4) Are incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap.

A covered Employee's Child is a Dependent only to the extent that each of the conditions under either Subsection (B), (C), or (D) of this Section 2.10 is satisfied. Upon the failure of a covered Employee's Child to satisfy any of these conditions, the Child will cease to be a Dependent on the fifteenth day or the last day of the month coincident with or next following the date on which the loss of eligibility occurs.

If a covered Employee claims a Child as a Dependent under this Section 2.10, the Plan Administrator may require the covered Employee to provide proof that each of the conditions under either Subsection (B), (C), or (D) of this Section 2.10 is satisfied.

If a covered Employee claims a Child as a Dependent under Subsection (D) of this Section 2.10, the covered Employee must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap. Such proof must be provided before coverage is continued under Subsection (D) of this Section 2.10. Additionally, such proof must be provided upon request at such time as the Plan Administrator may reasonably require. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. A Child who is a Dependent under Subsection (D) of this Section 2.10 is subject to all other provisions of this Medical Plan.

Further, notwithstanding any other provisions of this Medical Plan, no Dependent may be covered under this Medical Plan as a covered Dependent of more than one covered Employee, and no covered person may be covered hereunder as both a covered Employee and a covered Dependent.

Section 2.11 “Disability Date” means the date an Employee’s employment ends after the Employee qualifies as a Disabled Person under this Medical Plan.

Section 2.12 “Disabled Person” means an individual who meets either of the following conditions:

- (A) The individual is deemed disabled pursuant to the Long Term Disability Plan contained within the Farm Credit Foundations Employer Provided Welfare Benefits Plan; or
- (B) The individual is entitled to and is receiving benefits under the Farm Credit Foundations Long Term Disability Plan.

Evidence of continued disability status under the Long Term Disability Plan will be required and/or re-determination of disability status will be determined in accordance with written procedures as may be established by the Plan Administrator.

If at any time a Disabled Person becomes ineligible for disability status under the Medical Plan, such individual will no longer be an Eligible Disabled Person under this Medical Plan.

Section 2.13 “Eligible Disabled Person” means a Disabled Person who was enrolled in the Medical Plan on his/her Disability Date.

Section 2.14 “Eligible Employee” means a Regular Full-Time Employee or a Regular Part-Time Employee; provided, however, that an Employee’s status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer not to exceed six (6) months, during an unpaid leave of absence approved by the Employer not to exceed six (6) months, or, if FMLA is applicable to the Employer, during a leave of absence taken pursuant to FMLA.

Section 2.15 “Employee” means an individual employed by the Employer as a common law employee, excluding the following:

- (A) **Temporary Employees.** A Temporary Employee is a person who is employed on a temporary or contract basis to meet unusual workloads or demands or to fill in while a regular Employee is on extended, sick, or annual leave; and
- (B) **Leased Employees.** A Leased Employee is a person classified by the Employer on its payroll records as “leased employees” as that term is used in Code § 414(n); and
- (C) **Part-Time Without Benefits Employees.** A “Part-Time Without Benefits Employee” is an employee who is regularly scheduled to work less than twenty (20) hours per week.

Section 2.16 “Employer” means AgriBank, FCB; U.S. AgBank, FCB; Northwest Farm Credit Services; and each employer within the federal Farm Credit System who, with the permission of the Farm Credit Foundations Plan Sponsor Committee, has executed a Participation Agreement for this Medical Plan and the Participation Agreement remains in effect. Pursuant to the terms of the Administrative Agreement, the Plan Sponsor Committee is responsible for handling all settlor functions on behalf of the Employer under this Medical Plan.

Section 2.17 “FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.18 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.19 “Medical Plan” means the Farm Credit Foundations Medical Plan. The Medical Plan consists of this Wrap Around Plan Document, the Benefit Description, and the Benefit Schedules incorporated by reference and made a part of the Benefit Description.

Section 2.20 “Participant” means an Eligible Employee or Eligible Disabled Person who has entered the Medical Plan pursuant to Article III and whose participation in the Medical Plan has not been terminated pursuant to Article IV.

Section 2.21 “Plan Administrator” means the Farm Credit Foundations Trust Committee. The Farm Credit Foundations Trust Committee may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Medical Plan in a manner consistent with the terms of this Medical Plan.

Section 2.22 “Plan Sponsor Committee” means the Farm Credit Foundations Plan Sponsor Committee, as established by the Administrative Agreement.

Section 2.23 “Plan Year” means the fiscal year of this Medical Plan, the twelve (12) consecutive month period beginning every January 1 and ending the subsequent December 31.

Section 2.24 “Regular Full-Time Employee” means an Employee who is regularly scheduled to work at least 32 hours per week. Subject to Section 2.14, such status may be deemed to continue during any paid or unpaid leave of absence approved by the Employer or during any leave taken in accordance with FMLA.

Section 2.25 “Regular Part-Time Employee” means an Employee who is regularly scheduled to work at least twenty (20) hours per week, but not ordinarily equaling or exceeding 32 hours per week. Subject to Section 2.14, such status may be deemed to continue during any paid or unpaid leave of absence approved by the Employer or during any leave taken in accordance with FMLA.

Section 2.26 “Severance Period” means the period of time following an Employee’s termination of employment during which the Employee continues to receive compensation from the Employer pursuant to a plan or policy of the Employer providing such compensation to Employees whose employment has been involuntarily terminated.

Section 2.27 “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.28 “Wrap Around Plan Document” means this Medical Plan document, consisting of the Preamble through Article XIII of this Medical Plan, but not including the Benefit Description attached hereto, which this Wrap Around Plan Document incorporates by reference.

**ARTICLE III
ELIGIBILITY AND PARTICIPATION**

PART I – ELIGIBILITY REQUIREMENTS FOR EMPLOYEES & DISABLED PERSONS

Section 3.01 Requirements to Become a Participant – General Rule. In order to participate in this Medical Plan, an Employee must be an Eligible Employee or an Eligible Disabled Person as defined in Article II. Such Eligible Employee or Eligible Disabled Person shall become a Participant as follows:

- (A) **Eligible Employees.** If the Employee is an Eligible Employee, he/she must complete the waiting period as set forth in Section 3.03 and complete and return the applicable enrollment forms as set forth in Section 3.04.
- (B) **Eligible Disabled Employees.** If the Employee is an Eligible Disabled Person (and thus already enrolled in this Medical Plan as of his/her Disability Date), there is no waiting period and there are no new enrollment forms to complete. The Eligible Disabled Employee will remain covered under this Medical Plan following his/her Disability Date.

Section 3.02 Participation Restrictions on Certain Classes of Employees. In addition to the general rule set forth in Section 3.01, the following rules apply to certain classes of Employees:

- (A) **Rehired Participants.** If a Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant may again become a Participant in the Medical Plan pursuant to the provisions of this Section 3.01.
- (B) **Employees of Affiliating Employers.** In the case of any Employee of a Farm Credit System entity that becomes an Employer under this Medical Plan in accordance with Section 2.16 on or after January 1, 2007, the determination of whether such Employee is eligible for coverage under this Medical Plan shall be made in accordance with the provisions of the affiliation agreement entered into between AgriBank or U.S. AgBank and such Farm Credit System Employer, provided such provisions have been approved by the Plan Sponsor Committee. If such Employee is determined to be eligible for coverage under this Medical Plan, the Employee may become a Participant in this Medical Plan as of the date set forth in the affiliation agreement.
- (C) **Employees Changing Classification Status.** An Employee whose classification status changes from a Part-Time Without Benefits Employee, as defined in Section 2.15(C), to Regular Part-Time Employee or Regular Full-Time Employee may become a Participant in the Medical Plan on the first day of the pay period coincident with or next following the date of the change in classification status, provided that the Employee is an Eligible Employee (within the meaning of Section 2.14) and that the Employee has timely elected to participate in the Medical Plan pursuant to the requirements of Section 3.04.

Section 3.03 Waiting Period/Plan Entry Date. An Eligible Employee may become a Participant on the first day or the sixteenth day of the month coincident with or next following the Eligible Employee's first day of employment with the Employer, provided that the proper enrollment forms have been signed and received by the Plan Administrator within 45 days of the date the Employee becomes eligible to participate in this Medical Plan. If such forms are received after the Eligible Employee's first day of employment and *after* the first or sixteenth day of the month, as applicable, then such Eligible Employee will enter the Medical Plan on the first day or sixteenth day of the month next following enrollment. In addition, an Eligible Employee's coverage will be delayed until the date he/she returns to work if he/she is absent from work due to sickness, injury, or a temporary leave of absence on the date coverage would otherwise have been effective.

In determining when an Eligible Employee may enter this Medical Plan, any Eligible Employee who begins active employment on the first business day of the Employer during a calendar month shall be treated as having begun such employment on the first day of such calendar month. Similarly, if the sixteenth day of the month is not a business day of the Employer and an Eligible Employee begins active employment on the first business day following the sixteenth day of the month, the Eligible Employee shall be treated as having begun such employment on the sixteenth day of such calendar month.

Section 3.04 Election to Participate. In order to participate in this Medical Plan, an Employee must sign, and the Plan Administrator must receive, all proper enrollment forms within 45 days of the date the Employee becomes eligible to participate in the Medical Plan. The Plan Administrator may require the enrollment process to be completed and submitted in electronic form through the use of the internet, an intranet, a telephone system, or such other system as the Plan Administrator may prescribe. An Eligible Employee who does not timely sign and return the proper enrollment forms to the Plan Administrator shall not be eligible for coverage until the following Plan Year unless the Employee exercises special enrollment rights or experiences a change in status event pursuant to the provisions of Part III of this Article III.

PART II – ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Section 3.05 Employee Dependent Eligibility. Except as provided in Section 3.06 below, an Eligible Employee's Dependent(s) will be eligible to participate in the Medical Plan on the later of the following:

- (A) The same date on which the Eligible Employee satisfies the eligibility requirements of Sections 3.03 and 3.04; or
- (B) The date when such person(s) first come within the definition of Dependent(s) of an Eligible Employee.

Provided, however, that an eligible Dependent enrolled pursuant to Section 3.05(B) must be enrolled within 31 days of his/her eligibility date. Unless the special enrollment rules described in Part III of this Article III permit retroactive enrollment, such eligible Dependent's coverage will begin the first day or the sixteenth day of the month coincident with or next following the timely completion and submission of proper enrollment forms.

Section 3.06 Disabled Person Dependent Eligibility. Except as provided in Section 3.07 below, an Eligible Disabled Person's Dependent(s) will be eligible to participate in the Medical Plan as follows:

- (A) An Eligible Disabled Person's Dependent who was covered under this Medical Plan as a Dependent at the time of the Eligible Disabled Person's Disability Date shall remain covered as a Dependent without the need to complete any waiting period or to submit any additional forms;
- (B) An Eligible Disabled Person's Dependent who was not covered under this Medical Plan as a Dependent at the time of the Eligible Disabled Person's Disability Date shall be eligible to participate in this Medical Plan on the date such person first comes within the definition of a Dependent of an Eligible Disabled Person.

Provided, however, that an eligible Dependent enrolled pursuant to Section 3.06(B) must be enrolled within 31 days of his/her eligibility date. Unless the special enrollment rules described in Part III of this Article III permit retroactive enrollment, such eligible Dependent's coverage will begin the first day or the sixteenth day of the month coincident with or next following the timely completion and submission of proper enrollment forms.

Section 3.07 Dependents Ineligible for Dependent Coverage. Notwithstanding any other provision of this Medical Plan, an Employee's or Disabled Person's Dependent is not eligible for coverage under this Medical Plan if such Dependent is a member of the armed forces of any country, or if such Dependent is covered under this Medical Plan as an Employee.

Section 3.08 Employee/Dependent or Disabled Person/Dependent. If a husband and wife are both Eligible Employees and/or Eligible Disabled Persons, they may elect one of the following options:

- (A) The husband and wife may each enroll in single coverage; or
- (B) Either the husband or the wife may enroll in "Employee Plus Spouse Coverage" and cover the other spouse as a Dependent; or
- (C) Either the husband or the wife may enroll in "Family Coverage" (if there is more than one Dependent) covering the other spouse and any additional Dependents.

An Employee or Disabled Person who also qualifies as a Dependent may elect to be covered either as an Employee/Disabled Person or as a Dependent, but not as both an Employee/Disabled Person and a Dependent simultaneously. Further, under no circumstances will any Dependent be covered as a Dependent of more than one Employee and/or Disabled Person.

Section 3.09 Required Documentation of Dependent Status. The Plan Administrator reserves the right to require whatever documentation is necessary to determine, to the satisfaction of the Plan Administrator, an individual's status as a Dependent or as an Employee/Disabled Person.

PART III – SPECIAL ENROLLMENT PERIODS

Section 3.10 Special Enrollment Period. Notwithstanding any provision in this Article III to the contrary, an Employee or Dependent who does not elect coverage under this Medical Plan because such Employee or Dependent was covered under another group health plan or had other medical insurance coverage may enroll in this Medical Plan if such alternative coverage terminated because of an event specified in either Subsection (A) or Subsection (B) below:

- (A) There was a loss of eligibility for such alternative coverage. A loss of eligibility includes any of the following:
 - (1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment or reduction in the number of hours of employment, or exhaustion of the maximum COBRA period; or
 - (2) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits; or
 - (3) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area.

Note: A loss of eligibility does not include a loss resulting from the failure of the Employee or Dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

or

- (B) Employer contributions toward such other coverage ceased.

The special enrollment period expires 31 days after the alternative coverage terminates. Coverage elected during this special enrollment period will commence on the date that the alternative coverage terminated, provided that the Employee or Dependent timely submits his/her proper enrollment forms to the Plan Administrator.

Section 3.11 Enrollment Mid-Year Due to a Change in Status. An Employee and his/her covered Dependent(s) who did not timely enroll in the Medical Plan within 45 days of their initial eligibility date (as determined in this Article III) may be eligible to begin coverage before the end of the Plan Year (i.e., outside of the annual enrollment period) if the Employee experiences one of the change in status events set forth in Article V of the Farm Credit Foundations Flexible Benefits Plan. Provided, however, that the enrollment form for any such Employee and his/her Dependent(s) must be received by the Plan Administrator within 31 days after the date of the change in status event.

Section 3.12 Coverage of Dependents Enrolled Simultaneous with Employee.

If an Employee has one or more eligible Dependents on the date he/she becomes a Participant in this Medical Plan, and he/she elects "Family Coverage" (or "Employee Plus Spouse Coverage" or "Employee Plus Child(ren) Coverage"), the enrolled Dependents' coverage under this Medical Plan shall become effective on the same date on which coverage was effective for such Employee.

Section 3.13 Newly-Elected Coverage of Newly-Acquired (or Newly-Eligible) Non-Newborn Dependents.

If an Employee or Disabled Person acquires one or more Dependents (other than newborn infants described in Section 3,14 below) after the Employee's or Disabled Person's date of coverage (as determined under this Article III), or if the Employee's or Disabled Person's spouse or Child comes into conformity with the definition of Dependent after the Employee's or Disabled Person's date of coverage, and the Employee or Disabled Person thereupon or thereafter elects "Family Coverage" (or "Employee Plus Spouse Coverage" or "Employee Plus Child(ren) Coverage"), coverage for each such Dependent enrolled under this Medical Plan shall become effective on the date the Dependent was acquired, provided that a status change form and payment of the premium rate for Dependent coverage has been received by the Plan Administrator prior to such date. In any event, the status change form must be received within 31 days after the date such Dependent qualifies as an eligible Dependent. If a status change form has not been received within 31 days after the date such Dependent qualifies as an eligible Dependent, such Dependent will not be eligible for coverage until the following Plan Year.

Section 3.14 Newly-Elected Coverage of Newborn Dependents Acquired by Birth or Adoption.

If an Employee or Disabled Person first acquires a newborn Dependent after the Employee's or Disabled Person's date of coverage (as determined under this Article III), and thereon or thereafter elects "Family Coverage" (or "Employee Plus Child(ren) Coverage"), each such newborn Dependent's coverage under this Medical Plan shall be made effective as of the date of such Dependent's birth or adoption, as applicable, provided that a status change form and payment of the premium rate for Dependent coverage has been received by the Plan Administrator within 31 days after the date of the Dependent's birth or the date of the Dependent's adoption, as applicable. However, if, after 31 days, the Employee or Disabled Person has not elected a coverage option sufficient to include the new Dependent, enrolled such Dependent, and paid the appropriate premium, the Child will not be covered hereunder as a covered Dependent from the date of birth or adoption, as applicable. Rather, such Dependent will not be eligible for coverage until the following Plan Year.

Section 3.15 Extension of Existing Family Coverage. With respect to an extension of existing "Family Coverage" to newly-acquired or newly-eligible Dependents, such Dependents' coverage will become effective as follows:

- (A) **Newly-Acquired Newborn Dependents By Birth or Adoption.** If the Employee or Disabled Person has "Family Coverage" or "Employee Plus Spouse Coverage" or "Employee Plus Child(ren) Coverage," and thereafter acquires a newborn Dependent by birth or adoption, coverage for such newborn Dependent shall be made effective as of the date of such Dependent's birth or adoption, as applicable, provided that a status change form has been received by the Plan Administrator within 31 days of said date.

- (B) **Dependents Newly-Eligible for Reasons Other than Birth or Adoption.** If the Employee or Disabled Person has “Family Coverage” and thereafter the Employee’s or Disabled Person’s spouse or Child, who was not previously eligible or covered as a Dependent, comes into conformity with the definition of Dependent, coverage for such newly-eligible Dependent (and any other Dependent who enrolls pursuant to Section 3.16 below) shall be made effective as of the date such newly-eligible Dependent became an eligible Dependent under this Article III, provided that a status change form has been received by the Plan Administrator within 31 days of said date.

Section 3.16 **HIPAA Special Enrollment and the “Tag-Along Rule.”** If an Employee or Dependent enrolls in this Medical Plan pursuant to Section 3.10, all other Dependents who are eligible but not enrolled in the Medical Plan may enroll pursuant to this Article III.

**ARTICLE IV
DURATION OF COVERAGE**

Section 4.01 **Duration of Employee Coverage.** An Employee's coverage as a covered Employee under the Medical Plan shall terminate on the earliest of:

- (A) The date this Medical Plan terminates; or
- (B) The fifteenth day or the last day of the month coincident with or next following the date the Employee no longer satisfies the Medical Plan's Employee eligibility requirements; or
- (C) The date the Employee becomes covered under this Medical Plan as a Disabled Person pursuant to Section 2.11; or
- (D) The end of the period for which a required Employee contribution was last paid; or
- (E) The fifteenth day or the last day of the month coincident with or next following the date on which the Employee's employment terminates; or
- (F) The date on which the Employee becomes covered as a Dependent hereunder; or
- (G) The date on which the Employee becomes covered as a retiree under the Farm Credit Foundations Retiree Medical Plan; or
- (H) The date on which the Employer terminates participation in the Administrative Agreement.

If an Employee is on a leave of absence in accordance with FMLA and coverage lapses during the leave due to nonpayment of premiums, coverage shall be reinstated on the date the Employee returns to active work. In addition, where continuation coverage is elected under the Medical Plan by a terminated Participant, such terminated Participant will not cease participation in this Medical Plan until the date such continuation coverage terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Article VI.

Upon termination of an Employee's coverage, the Plan Administrator, or its designee, shall provide the Employee with a Certificate of Creditable Coverage, provided such Employee does not become covered under this Medical Plan as a Disabled Person.

Section 4.02 **Duration of Disabled Person Coverage.** A Disabled Person's coverage as a covered Disabled Person under the Medical Plan shall terminate on the earliest of:

- (A) The date this Medical Plan terminates; or
- (B) The fifteenth day or the last day of the month coincident with or next following the sixty-fifth birthday of the Disabled Person (i.e., the date on which the Disabled Person becomes eligible to be covered as a Retiree under the Farm Credit Foundations Retiree Medical Plan); or
- (C) The fifteenth day or the last day of the month coincident with or next following the date the Disabled Person no longer satisfies the Medical Plan's eligibility requirements for Disabled Persons; or
- (D) The end of the period for which a required Disabled Person's contribution was last paid; or
- (E) The date on which the Disabled Person becomes covered as a Dependent hereunder; or
- (F) The date the Disabled Person commences benefits under his/her Employer's pension plan, provided that the Disabled Person is eligible to participate in the Farm Credit Foundations Retiree Medical Plan; or
- (G) The Disabled Person's death.

Upon termination of a Disabled Person's coverage, the Plan Administrator, or its designee, shall provide the Disabled Person with a Certificate of Creditable Coverage.

Section 4.03 Duration of Dependent Coverage. A Dependent's coverage under the Medical Plan shall terminate on the earliest of:

- (A) The date of termination of coverage of the Employee or Disabled Person through whom the Dependent is covered; or
- (B) The fifteenth day or the last day of the month coincident with or next following the date the Dependent no longer meets the Medical Plan's definition of "Dependent" or no longer satisfies the Medical Plan's eligibility requirements; or
- (C) The fifteenth day or the last day of the month coincident with or next following the date the Dependent enters active service in the armed forces of any country, except temporary active service of two (2) weeks or less; or
- (D) The end of the period for which a Employee or Disabled Person's required contribution was last paid; or
- (E) The date upon which the Dependent becomes covered hereunder as an Employee or Disabled Person.

Upon termination of a Dependent's coverage, the Plan Administrator, or its designee, shall provide the Dependent with a Certificate of Creditable Coverage.

ARTICLE V MEDICAL BENEFITS

Section 5.01 Medical Benefits. Medical benefits under this Medical Plan are identical to those described in, and shall be paid pursuant to the terms of, the current Benefit Description, attached to this Wrap Around Plan Document. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the Benefit Description; provided, however, that should there be any contradictions between the benefit options listed on the Benefit Description and this Wrap Around Plan Document, this Wrap Around Plan Document will control.

Section 5.02 Benefit Options and Annual Enrollment Period.

- (A) **Benefit Election Form.** As set forth in Section 3.04, if an Eligible Employee or wishes to participate in this Medical Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Farm Credit Foundations Flexible Benefits Plan, to reduce the Employee's compensation in the amount of the applicable premium under Section 5.03.
- (B) **Benefit Options.** Participants may choose from multiple benefit options as set forth in the Benefit Description. The availability of certain benefit options may vary depending on the Participant's state of residency. Any election shall apply to both the Participant and any Dependent(s) for whom the Participant has elected coverage.
- (C) **Ability to Change Benefit Options During Annual Enrollment Period.** Participants make an annual decision regarding their coverage under this Medical Plan. During this annual enrollment period, Participants may select a different benefit option, terminate their coverage, and/or add or terminate any Dependent's coverage. Coverage changes elected during the annual enrollment period shall be effective at the beginning of the next Plan Year.
- (D) **Ability to Change Benefit Options Outside of Annual Enrollment Period.** Outside of the annual enrollment period, Participants may not change their benefit options, terminate their coverage, and/or add or terminate any Dependent's coverage unless such a change is expressly authorized by Part III of Article III.

Section 5.03 Cost of Coverage. Monthly premiums are determined by the Plan Sponsor Committee and may be changed from time to time. The Plan Sponsor Committee will designate, for each Plan Year, the portion of the monthly premium for which the Participant shall be responsible for payment, and the portion of the monthly premium for which the Employer shall be responsible for payment (i.e., the Employer subsidy). If the Participant is a covered Disabled Person, his/her coverage shall be subsidized by the Employer for two years, measured from his/her Disability Date. After the two-year period, the covered Disabled Person must pay for the full cost of his/her coverage option.

**ARTICLE VI
CONTINUATION OF COVERAGE**

Section 6.01 Continuation of Coverage. If a “qualified beneficiary” loses (or would lose) coverage under this Medical Plan as a result of a “qualifying event” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a continuation of coverage election form and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Medical Plan is subject to the following:

- (A) **Qualified Beneficiary.** For purposes of this Section, a “qualified beneficiary” means the Participant, the Participant’s spouse, and the Participant’s Dependents, but only if such persons were covered under this Medical Plan on the day before the “qualifying event.” The term “qualified beneficiary” shall also include any Children who are born to or acquired by the Participant while the Participant is continuing his/her coverage.

- (B) **Qualifying Event.** For purposes of this Section, a “qualifying event” means one of the following, if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Medical Plan as a result of such an event:
 - (1) Termination of the Participant’s employment (other than for “gross misconduct”) or a reduction in the number of hours the Participant normally works.
 - (2) Death of the Participant.
 - (3) Divorce or legal separation of the Participant and the Participant’s covered spouse.
 - (4) The Participant’s entitlement to Medicare.
 - (5) A covered Dependent no longer satisfies the conditions for being covered as a Dependent of the Participant.

- (C) **Election to Continue Coverage.** Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the Plan Administrator and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

- (D) **Premium for Continuation Coverage.** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

- (E) **Maximum Coverage Period.** The maximum period of time for which continuation coverage will be provided shall be as follows:
- (1) Termination of Employment or Reduction in Hours. If coverage was lost due to a Participant's termination of employment or reduction in hours, the maximum period of continuation coverage shall be eighteen (18) months.
 - (2) Disability Extension. If coverage was lost due to a Participant's termination of employment or reduction in hours, and a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of the continuation coverage, the maximum period of continuation coverage shall be extended to twenty-nine (29) months, provided that the qualified beneficiary notifies the Plan Administrator of such disability determination while continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.
 - (3) Second Qualifying Event. If coverage was lost due to a Participant's termination of employment or reduction in hours, and a qualified beneficiary experiences a second qualifying event while coverage is being continued following the original qualifying event, the maximum period of continuation coverage shall be thirty-six (36) months.
 - (4) Any Other Qualifying Event. The maximum period of continuation coverage for a Dependent – not the Participant – shall be thirty-six (36) months if the Dependent's coverage was lost as a result of any of the following:
 - (a) The Participant's death; or
 - (b) The Participant's divorce or legal separation from his/her covered Dependent spouse; or
 - (c) The Participant's entitlement to Medicare; or
 - (d) A covered Dependent no longer satisfying the conditions for being covered as a Dependent of the Participant.
- (F) **Termination of Continuation Coverage.** Continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Medical Plan and no longer offers coverage under a group health plan to any of its Employees.

- (G) **Coverage Provided During Continuation Period.** The coverage provided during the continuation period shall be identical to the coverage provided to similarly situated persons covered under the Medical Plan with respect to whom a qualifying event has not occurred. If coverage under the Medical Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue his/her coverage.
- (H) **Calculation of Continuation Coverage Deadlines.** The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Medical Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

Section 6.02 Waiver of Continuation Coverage. In lieu of continuing coverage under this Medical Plan, a Participant may elect coverage under the Farm Credit Foundations Retiree Medical Plan if the Participant meets the eligibility conditions set forth in such plan. The Participant may not elect continuation coverage under this Medical Plan followed by coverage under the Farm Credit Foundations Retiree Medical Plan.

- (A) **Exception to General Rule.** Notwithstanding the above general rule, Participants who have entered into a severance agreement with the Employer may be permitted to continue coverage under the Medical Plan through the last day of the severance period established by the former Employer, but in no case exceeding eighteen (18) months, followed by coverage under the Farm Credit Foundations Retiree Medical Plan (if eligible for such plan) if provided under the terms of the severance agreement.

A former Employee whose coverage is continued pursuant to this Section 6.02(A) shall be responsible for payment of the Employee portion of the cost of coverage during the severance period (not exceeding eighteen (18) months), which amount shall be calculated as if the former Employee were still an Employee. A former Employee whose coverage is continued pursuant to this Section 6.02(A) may not change his/her coverage except as otherwise permitted under Article V of the Farm Credit Foundations Flexible Benefits Plan.

- (B) **Special Rule for Dependents.** Even if a Participant waives continuation coverage under this Medical Plan and elects to participate in the Farm Credit Foundations Retiree Medical Plan, a Dependent of the Participant may choose to elect continuation coverage under this Medical Plan in lieu of coverage under the Farm Credit Foundations Retiree Medical Plan.

Section 6.03 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. If, however, a Participant exercised his/her right to continue coverage under USERRA before December 10, 2004, the Participant's right to continue coverage is limited to a maximum period of eighteen (18) months if such coverage would otherwise be lost as a result of such military service. The Participant's right to continue coverage is subject to the following:

- (A) **Payment of Premium.** The Participant must pay the applicable premium for any USERRA continuation coverage.
- (B) **Failure to Apply for Reemployment.** Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA. 43 U.S.C. § 4312(c).
- (C) **Reasonable Procedures.** The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.
- (D) **Construction and Application.** This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute.

Section 6.04 Special Rule for Insured Benefit Options Set Forth on the Benefit Description. The provisions of Sections 6.01 and 6.02 above do not apply to Participants and Dependents covered under an insured option set forth in the Benefit Description, which is attached to this Wrap Around Plan Document. Such individuals are subject to the continuation of coverage provisions of the applicable insured benefit option.

**ARTICLE VII
HIPAA MEDICAL PRIVACY AND SECURITY**

PART I - PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy and Security Article is adopted in response to the provisions of the Medical Privacy and Security Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 7.02 Application of Amendment. This Article shall supersede the provisions of the Medical Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 7.03 Relationship to Other Group Health Plans. The Plan is part of an “organized health care arrangement” (“OHCA”) with the following plans maintained by the Employer:

- (A) The Farm Credit Foundations Dental Plan; and
- (B) The Farm Credit Foundations Retiree Medical Plan; and
- (C) The Health Flexible Spending Account that is a component of the Farm Credit Foundations Flexible Benefits Plan.

The plans that are part of the OHCA as set forth above may be collectively referred to in this Article VII as the “Group Health Plan.”

PART II – DISCLOSURE OF PHI TO THE EMPLOYER

Section 7.04 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by Part II of this Article VII, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information or electronic Protected Health Information to the Employer.

Section 7.05 Definitions. For purposes of this Article VII, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

- (A) **“De-identified Health Information”** means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

- (B) **“Electronic Media”** means
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
 - (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (C) **“Electronic Protected Health Information” (“e-PHI”)** is PHI that is transmitted or maintained in electronic media.
- (D) **“Individually Identifiable Health Information”** means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse; and
 - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
 - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (E) **“Plan Administration Functions”** means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan that is not part of the same OHCA as the Medical Plan.
- (F) **“Protected Health Information” (“PHI”)** means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

- (G) **“Security Incident”** (as defined in 45 C.F.R. § 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (H) **“Security Rule”** shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.
- (I) **“Summary Health Information”** means information that summarizes the claims history, Claims expenses, and/or types of Claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.

Section 7.06 Enrollment/Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.07 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (A) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan; and
- (B) Overseeing the adjudication of benefit Claims, including the responsibility to provide coverage upon the initial submission of Claims and the disposition of any appeals that are filed with respect to Claims that are denied in whole or in part; and
- (C) Overseeing the coordination of benefits and pursuing and/or responding to Claims for subrogation; and
- (D) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits; and
- (E) Detecting fraud or abuse; and
- (F) Determining whether charges for services are appropriate or justified; and
- (G) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance; and

- (H) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess-loss insurance in the event the Group Health Plan is self-insured in whole or in part; and
- (I) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate; and
- (J) Providing assistance, upon request, to Participants and their covered Dependents in addressing and resolving problems that they may encounter with the approval and payment of Claims that have been submitted on their behalf; and
- (K) Reporting corporate finances with respect to current and projected healthcare costs; and
- (L) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (M) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.07 is subject to the provisions of Section 7.08.

Section 7.08 Conditions for Disclosure for Plan Administration Functions.

With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.07, the Employer agrees to do the following:

- (A) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law; and
- (B) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI; and
- (C) Not use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer; and
- (D) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information; and

- (E) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in 45 C.F.R. § 164.524; and
- (F) Make PHI or e-PHI available for amendment and incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526; and
- (G) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528; and
- (H) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy requirements; and
- (I) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (J) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
 - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI; and
 - (2) Ensure that any agent (including subcontractors) to whom it provides such e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and
 - (3) Report to the Group Health Plan any Security Incident of which it becomes aware.
- (K) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III of this Article VII; and
- (L) Provide a certification to the Group Health Plan as required by Section 7.09.

Section 7.09 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.08 of Part II of this Article VII.

PART III - ADMINISTRATIVE SAFEGUARDS

Section 7.10 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III of Article VII. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article VII does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.11 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants: (a) Those Employees of the Employer who have the responsibility for administering the benefit programs of the Employer, including, but not limited to, all Employees who serve on or are appointed by the Farm Credit Foundations Trust Committee and all Employees in the benefits section of the AgriBank Benefits Department, (b) Members of the Farm Credit Foundations Trust Committee, and (c) the Internal Counsel of the Farm Credit Foundations Trust Committee and his/her support staff in the legal department, but only for the limited purposes of ensuring investigation of and responding to complaints alleging violations of the policies and procedures established by the Employer.

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the information technology department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer; and/or providing legal advice or counsel with respect to pending Claims.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy rules and shall comply fully with the Group Health Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.12 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.13 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III of Article VII, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

ARTICLE VIII
ADMINISTRATION OF THE MEDICAL PLAN

Section 8.01 Plan Administrator. The Plan Administrator is the Farm Credit Foundations Trust Committee. The Plan Administrator is responsible for the administration of the Medical Plan. The Plan Administrator has the full discretionary authority to administer the Medical Plan, subject to the requirements of law. Except as otherwise provided by law or otherwise delegated in this Medical Plan, all decisions of the Plan Administrator are final and binding on all parties. For this purpose, the Plan Administrator, in addition to such other powers as the law may provide, has the following powers to:

- (A) Establish rules and procedures for the purpose of the administration of this Medical Plan; and
- (B) Require each Participant to supply such information and sign such documents as may be necessary to administer this Medical Plan; and
- (C) Interpret, construe and carry out the provisions of the Medical Plan and render decisions on the administration of the Medical Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of this Medical Plan; and
- (D) Appoint such agents, attorneys, accountants and consultants and any other person required for proper administration of the Medical Plan.

The Plan Administrator shall keep all books, accounts, records and other data as may be necessary for the proper administration of the Medical Plan.

Section 8.02 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Medical Plan in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.

**ARTICLE IX
CLAIMS PROCEDURES FOR SELF-FUNDED
MEDICAL AND PRESCRIPTION DRUG BENEFIT OPTIONS**

PART I – GENERAL PROVISIONS

Section 9.01 Claims Administrator. The Claims Administrator with respect to any Claim for benefits, other than prescription coverage, under a self-funded PPO option – as set forth in the Benefit Description – is BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, Illinois 60680-4112. (Relevant internet information may be found at www.bcbsil.com/foundations.) The Claims Administrator with respect to any Claim for prescription benefits under a self-funded PPO option, as set forth in the Benefit Description, is CVS Caremark, P.O. Box 686005, San Antonio, Texas, 78268-6005. (Relevant internet information may be found at www.caremark.com.) Both Claims Administrators may be contacted by telephone at 1-866-563-8366.

Fiduciary responsibility for Claims administration is delegated to the applicable Claims Administrator as provided in Section 405(c) of ERISA just as though the Medical Plan were not a “governmental plan,” but a plan fully subject to Title I of ERISA as to the duties and responsibilities of the Claims Administrator. The Claims Administrator has the ultimate responsibility for the final determination of all Claims made under the Medical Plan except to the extent, and only to the extent, that a Claim requires a determination to be made as to whether a given individual was eligible to be, and in fact was, covered under the Medical Plan at the time the Claim was incurred. The Claims Administrator shall have the sole and exclusive discretion and power to grant and/or deny all Claims for benefits. No finding, decision, and/or determination made by the Claims Administrator shall be disturbed unless the Claims Administrator has acted in an arbitrary or capricious manner.

Section 9.02 Duties of the Claims Administrator. The applicable Claims Administrator shall have the discretionary power and authority to perform the following duties and responsibilities:

- (A) Receive Claims for benefits and render decisions with respect to either medical or prescription Claims under the Medical Plan; and
- (B) Compute the amounts payable for any Participant or other person in accordance with the provisions of the Medical Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid; and
- (C) Make discretionary interpretations regarding the terms relating to administration of Claims under the Medical Plan, its interpretations to be final and conclusive on all persons claiming benefits under the Medical Plan; and
- (D) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of Claims under the Medical Plan; and
- (E) Adopt such rules and procedures relating to the administration of Claims as it deems necessary or desirable; and

- (F) Be responsible for all Claims administration reporting and disclosure requirements for the Medical Plan under the law; and
- (G) Receive from the Employer, Employees, Participants and other persons such information as shall be necessary for the proper administration of Claims under the Medical Plan; and
- (H) Maintain all Claims administration records of the Medical Plan.

The applicable Claims Administrator shall also handle appeals for benefits in accordance with this Article IX and the applicable benefit option set forth in the Benefit Description.

PART II – CLAIMS FOR MEDICAL BENEFITS (OTHER THAN PRESCRIPTIONS)

Section 9.03 Claims for Medical Benefits (Other Than Prescriptions). The Claims procedures outlined in Part II of this Article IX shall apply to all Claims for medical benefits and services other than prescription benefits. Prescription benefit Claims procedures are governed by Part III of this Article IX.

Section 9.04 How to File a Claim.

- (A) **Claim Filed by Hospital or Physician.** In order to obtain medical benefits under this Medical Plan, a Claim must be filed with the Claims Administrator. To file a Claim, the Participant must show his/her ID card to the Provider who is providing the service. The Provider shall file the Claim on behalf of the Participant. The Participant shall have the responsibility to ensure that the necessary Claim information has been provided to the Claims Administrator.

The Claim shall be processed by the Claims Administrator when it receives the Claim. The benefit payment shall be sent directly to the Hospital or Physician. The Claims Administrator shall provide the Participant a statement informing him/her of the amount of the Claim paid on his/her behalf. If necessary, the Claims Administrator shall send the payment directly to the Participant or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claims Administrator's records.

- (B) **Exceptions to Filing By Hospital or Physician.** Under certain circumstances, Claims must be filed by the Participant. The Participant must file his/her own Claim if the Participant receives services or supplies from a non-PPO provider or Hospital or from Providers other than a Hospital or Physician. For example, if the Participant has ambulance expenses, he/she must file his/her own Claim. Such Claim must be filed as follows:

- (1) **Claim Form.** A Claim form must be completed. Claim forms are available from the Plan Administrator or from the Claims Administrator's office; and

- (2) **Copies of Bills.** Copies of all bills to be considered for benefits must be attached to the Claim form. The bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim charge; and
- (3) **Mailing Address.** The completed Claim form with attachments must be mailed to BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, IL 60680-4112.

Section 9.05 Claims Procedures. Claims made for benefits under the Medical Plan shall be processed in accordance with the following procedures:

- (A) **Claims.** Written proof describing the occurrence, character and/or extent of a loss or expense for which a Claim is made must be given to the Claims Administrator within twelve (12) months of the date medical service was provided. Claims may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.
- (B) **Form of Claims.** Claims for benefits must be made by the Claimant in such form as the Claims Administrator may prescribe and shall include the following information:
 - (1) The amount, date and nature of each expense; and
 - (2) The name of the person, organization or entity to which the expense was/is to be paid; and
 - (3) The Group Number identifying the Medical Plan; and
 - (4) The name of the Participant for whom the expense was incurred and, if such person is not the Employee or Disabled Person requesting the benefit, the relationship of such Participant to the Employee or Disabled Person; and
 - (5) The amount recovered or expected to be recovered, under any insurance arrangement or other plan (including Medicare, as reflected on the Explanation of Medicare Benefits), with respect to the expense.
- (C) **Delayed Submission of Claims.** If the required proof of expense or loss is not given by the time it is due, it will not affect the Claim if:
 - (1) It was not possible to give the required proof within the required time; and
 - (2) The required proof is given as soon as possible.

- (D) **Payment of Claims.** The Medical Plan shall pay benefits with respect to covered expenses, as determined by the Claims Administrator, typically within thirty (30) days of the receipt of all the necessary information on the Claim for benefits. Covered persons may elect to have benefits paid directly to themselves, or may assign benefits so that payment is made directly to the Hospital or person providing the covered service. By virtue of any such payment, the Employer and Medical Plan shall be released from further liability for any amount so paid. For more information regarding the assignment of benefits, see the provision entitled, "Submission of Claims, Payment of Claims and Assignment of Benefits" within Section XIX of the Benefit Schedule.
- (E) **Denial of Claims.** If a Claim for benefits is denied in whole or part, the Claims Administrator shall, within a reasonable period of time, but no later than thirty (30) days after receipt of the Claim and all necessary information related thereto, notify the Claimant of the denial of the Claim. This period, however, may be extended by fifteen (15) days, provided that the Claims Administrator determines that such an extension is necessary and notifies the Claimant of the extension before the end of the initial 30-day period. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall have at least forty-five (45) days from receipt of the notice to provide the specified information.

Such notice of denial:

- (1) Shall be in writing; and
 - (2) Shall be written in a manner calculated to be understood by the Claimant; and
 - (3) Shall contain --
 - (a) The specific reason(s) for denial of the Claim; and
 - (b) A specific reference to the pertinent Medical Plan provisions upon which the denial is based; and
 - (c) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation of why such material or information is necessary; and
 - (d) An explanation of the Medical Plan's Claims review procedures.
- (F) **First Level Appeal of Claim Denial to Claims Administrator.** Upon denial of a Claim in whole or in part, the Claimant or his/her duly authorized representative shall have 180 days within which to file with the Claims Administrator a written request for a review of such denial, whereupon:

- (1) The Claims Administrator shall act as promptly as is practicable, ordinarily within sixty (60) days; and
- (2) The Claimant or his/her duly authorized representative shall, pending said review, be permitted at all reasonable hours to review the pertinent documents and also be entitled to submit issues, comments and additional medical information in writing.

A copy of the Claim form, x-rays, and clinical comments must be submitted to BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, IL 60680-4112.

- (G) **Decision on Review by Claims Administrator.** If the Claims Administrator determines that an additional amount is due, it shall pay any such amount. If the Claims Administrator determines that the Claim is not meritorious, in whole or in part, the Claims Administrator shall notify the Claimant accordingly within sixty (60) days after it receives the request for review.
- (H) **Second Level Appeal of Claim Denial to Claims Administrator/Medical Review Board.** Following the initial appeal to the Claims Administrator on any denied Claim, the Claimant or his/her duly authorized representative may make a second appeal to the Claims Administrator for a full review of the denied Claim. This second level of appeal shall be forwarded by the Claims Administrator to a third party medical review board. The Claimant or his/her duly authorized representative shall submit all necessary information to evaluate the Claim within 90 days of the initial denial of the Claim by the Claims Administrator. Such information shall include the following:
- (1) The name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant; and
 - (2) The amount and date of the expense(s) incurred; and
 - (3) The specific medical condition or symptom upon which the Claim is based; and
 - (4) The specific treatment, service, or product for which approval or payment is being requested; and
 - (5) The specific terms of the Medical Plan that the Claimant is relying on in support of the Claimant's assertion that the Claim is properly payable under the terms and conditions of the Medical Plan; and
 - (6) An explanation by the Claimant as to why the Claimant believes the reasoning of the Claims Administrator in denying the Claim is incorrect; and why the Claimant believes the Claim is properly payable under the terms and conditions of the Medical Plan.

If Claim information is incomplete, the medical review board reserves the right to request any additional information necessary to finalize the Claim.

- (I) **Access to Relevant Information.** Upon timely request, a Claimant shall be provided reasonable access to, and copies of, documents, medical records, and other information relevant to his/her appeal of the denied Claim for benefits.
- (J) **Decision on Review by the Claims Administrator/Medical Review Board.** A decision will be made by the third party medical review board no more than 90 days after the request for review, and any request for additional information, is received by the Claims Administrator or board. Any decision by the medical review board denying the Claim in whole or in part shall be in writing and shall include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision of the medical review board shall be final and binding.

PART III – CLAIMS FOR PRESCRIPTION BENEFITS

Section 9.06 Claims for Prescription Benefits. The Claims procedures outlined in Part III of this Article IX shall apply only to Claims for prescription benefits. Claims for other medical benefits and services are governed by Part II of this Article IX.

Section 9.07 How to File a Claim. In order to obtain prescription benefits under this Medical Plan, a Claim must be filed with the Claims Administrator. The procedures for filing the Claim with the Claims Administrator vary, depending on whether the Participant's prescription is filled at a Network Retail Pharmacy, a Mail Order Pharmacy, or a Non-Network Retail Pharmacy (as those terms are defined in the Benefit Schedules).

- (A) **Mail Order Pharmacy.** If a Participant chooses to have his/her prescription filled through a Mail Order Pharmacy, he/she must complete a Participant Profile/Order Form, which shall be made available by the Plan Administrator. This form must then be sent, along with any required documents and any applicable co-payment or co-insurance, to the Claims Administrator's Mail Order Pharmacy at the following address: Caremark, P.O. Box 659529, San Antonio, Texas, 78265-9529. The Claims Administrator shall process the Claim after the Mail Order Pharmacy has filled the prescription.
- (B) **Network Retail Pharmacy.** If a Participant chooses to have his/her prescription filled at a Network Retail Pharmacy, the Participant must present his/her Medical Plan identification card to the Network Retail Pharmacy at the time of purchase. After the Participant has paid any applicable co-payment or co-insurance, the Network Retail Pharmacy will file a Claim on the Participant's behalf. The Claims Administrator shall process the Claim after receiving it from the Network Retail Pharmacy.

If the Participant's prescription is filled at a Network Retail Pharmacy, but the Participant fails to present his/her Medical Plan identification card at the time of purchase, the Participant must pay the full cost of the prescription to the Network Retail Pharmacy and then file a Claim for reimbursement with the Claims Administrator.

- (C) **Non-Network Retail Pharmacy.** If the Participant chooses to have his/her prescription filled at a Non-Network Retail Pharmacy, the Participant must pay the full cost of the prescription to the Non-Network Retail Pharmacy and then file a Claim for reimbursement with the Claims Administrator.
- (D) **Claim Reimbursement Submissions.** A Participant seeking reimbursement for prescription benefits from the Claims Administrator must complete a Prescription Drug Claim form and return it to the Claims Administrator.
 - (1) Claim Forms. Prescription Drug Claim forms shall be made available by the Plan Administrator.
 - (2) Required Receipts. The Prescription Drug Claim form must be accompanied by a receipt for each prescription medication. Each receipt must show: the patient's name, the prescription number, the Pharmacy name and address, the name and strength of the drug, the quantity of the drug, an indication whether the prescribing Physician directed that the prescription be dispensed as written, the Physician's name or DEA number, the date of purchase, and the total charge for the prescription.
 - (3) Mailing Address. The completed Prescription Drug Claim form with attachments must be mailed to:

Caremark, Inc.
P.O. Box 686005
San Antonio, Texas, 78268-6005

Section 9.08 Claims Procedures. Claims made for prescription benefits under the Medical Plan shall be processed in accordance with the following procedures:

- (A) **Claims.** A Participant seeking reimbursement for prescription benefits must submit a Prescription Drug Claim form (along with any required receipts or other documentation) to the Claims Administrator within twelve (12) months of the date of purchase.
- (B) **Payment of Claims.** The Medical Plan shall pay benefits with respect to covered prescription expenses, as determined by the Claims Administrator, typically within thirty (30) days of the receipt of all necessary Claim reimbursement information.
- (C) **Denial of Claims.** If a Claim for prescription benefits is denied in whole or part, the Claims Administrator shall, within a reasonable period of time, but no later than thirty (30) days after receipt of the Claim and all necessary information related thereto, notify the Claimant of the denial of the Claim.

Such notice of denial:

- (1) Shall be in writing; and

- (2) Shall be written in a manner calculated to be understood by the Claimant; and
 - (3) Shall contain –
 - (a) The specific reason(s) for denial of the Claim; and
 - (b) A specific reference to the pertinent Medical Plan provisions upon which the denial is based; and
 - (c) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation of why such material or information is necessary; and
 - (d) An explanation of the Medical Plan's Claims review procedures.
- (D) **Appeal to Claims Administrator.** Upon denial of a Claim in whole or in part, the Claimant or his/her duly authorized representative shall have 180 days within which to file a written request for a review of such denial with the Claims Administrator for prescription benefits.
- (1) To appeal a denied Claim for prescription benefits, the Claimant or his/her duly authorized representative must complete a Prescription Claim appeal form. This form shall be made available to Participants by the Plan Administrator.
 - (2) The Prescription Claim appeal form must be accompanied by –
 - (a) A copy of the relevant benefits denial letter that the Claimant received from the Claims Administrator; and
 - (b) A copy of the Claimant's payment receipt for the prescription medication; and
 - (c) Any Physician letter(s) in support of the appeal.
 - (3) The Prescription Claim appeal form and all supporting materials must be submitted to the Claims Administrator via mail or fax machine (toll free). The contact information is as follows:

Prescription Claim Appeals MC 109
Caremark PCS
P.O. Box 52084
Phoenix, AZ 52084
Fax: (866) 443-1172

- (E) **Decision on Review by Claims Administrator.** In evaluating a Claimant's appeal, the Claims Administrator shall review the Claimant's Prescription Claim appeal form and all supporting documentation and materials. If the appeals determination requires clinical knowledge (e.g., prescriptions that involve pre-authorization or pre-approval), a staff pharmacist shall review the Claim. The Claims Administrator shall rule on denied prescription Claims appeals under the following schedule:
- (1) Urgent Care Appeals. Appeals involving Claims for prescription benefits where a Physician (or the Plan Administrator, using judgment of a prudent layperson) has specified that the Claimant's need for the medication may be urgent will be decided within seventy-two (72) hours of the time the Claims Administrator receives all relevant Claims information from the Claimant.
 - (2) Pre-Authorization/Pre-Approval Prescription Benefit Appeals. Appeals involving Claims for prescription benefits that require pre-authorization or pre-approval (i.e., the prescription cannot be filled until the appropriate authorization/approval is received) will be decided within fifteen (15) days of the date the Claims Administrator receives all relevant Claims information from the Claimant.
 - (3) Reimbursement Appeals. Appeals involving Claims for prescription benefits where the Claimant has already received the medication and is requesting reimbursement will be decided within thirty (30) days of the date the Claims Administrator receives all relevant Claims information from the Claimant.
- (F) **Second Level of Appeal to Claims Administrator for Pre-Authorization/Pre-Approval Prescription Benefit Appeals.** Following the initial appeal to the Claims Administrator on any denied Claim for prescription benefits that requires pre-authorization or pre-approval, the Claimant or his/her duly authorized representative may make a second appeal to the Claims Administrator for an additional review of the denied Claim. This second level of appeal shall be forwarded by the Claims Administrator to a third party medical review board (i.e., an independent external review organization).
- (1) Limited Appeal Rights. This second level of appeal is available only for denied Claims for prescription benefits that require pre-authorization or pre-approval. For all other prescription benefit denied Claim appeals, the Claims Administrator's initial denial of the appeal is final.
 - (2) Required Information in Appeal. If a Claimant makes a second appeal to the Claims Administrator, the Claimant or his/her duly authorized representative shall submit all necessary information to evaluate the Claim within 30 days of the initial denial of the Claim by the Claims Administrator. Such information shall include the following:
 - (a) The name of the Claimant; and

- (b) The amount and date of the expense(s) incurred; and
- (c) The specific medical condition or symptom upon which the Claim is based; and
- (d) The prescription medication – drug name, strength, and quantity/dosage – for which authorization or approval is being requested; and
- (e) The specific terms of the Medical Plan that the Claimant is relying upon in support of his/her assertion that the Claim is properly payable under the terms and conditions of the Medical Plan; and
- (f) An explanation by the Claimant as to why the Claimant believes the initial decision of the Claims Administrator in denying the Claim is incorrect; and why the Claimant believes the Claim is properly payable under the terms and conditions of the Medical Plan.

If Claim information is incomplete, the medical review board reserves the right to request any additional information necessary to finalize the Claim.

- (G) **Access to Relevant Information.** Upon timely request, a Claimant shall be provided reasonable access to, and copies of, documents, medical records, and other information relevant to his/her appeal of the denied Claim for prescription benefits.
- (H) **Decision on Review by the Claims Administrator/Medical Review Board.** A decision shall be made by the third party medical review board no more than 90 days after the request for review, and any request for additional information, is received by the Claims Administrator or board. Any decision by the medical review board denying the Claim in whole or in part shall be in writing and shall include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision of the medical review board shall be final and binding.

PART IV – LITIGATION OF DENIED CLAIM APPEALS

Section 9.09 Litigation of Claim. Prior to initiating legal action concerning a Claim for benefits in any court, state or federal, against the Medical Plan, any trust used in conjunction with this Medical Plan, the Employer, and/or the Plan Administrator, a Claimant must first exhaust the administrative remedies provided in this Article IX. Failure to exhaust the administrative remedies provided for in this Article IX shall be a bar to any civil action concerning a Claim for benefits under the Medical Plan. If the Claims Administrator, acting pursuant to the Medical Plan's written Claims procedure, makes a final written determination denying a Claim, the Claimant, to preserve the Claim, must file an action with respect to the denied Claim not later than one (1) year following the date of the Claims Administrator's final determination.

ARTICLE X
CLAIMS PROCEDURES FOR HMO OPTIONS
AND FULLY INSURED PPO OPTIONS

Section 10.01 Claims Administrator. The Claims Administrator(s) of the HMO options and fully insured PPO options are set forth in the applicable Benefit Schedules incorporated by reference and made a part of the Benefit Description. The Claims Administrator(s) is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of benefit Claims in accordance with the terms of the applicable group contract. Except as provided by law, all decisions of the Claims Administrator(s) shall be final and binding.

Section 10.02 How to File a Claim. Any Claim for benefits shall be filed in accordance with the Claims procedures set forth in the applicable HMO option or fully insured PPO option (e.g., HMSA PPO option) in the Benefit Description.

Section 10.03 Claims Procedures. The procedures for appealing any denial of a benefit Claim are set forth in the applicable HMO option or fully insured PPO option and must be followed accordingly.

**ARTICLE XI
SUBROGATION AND REIMBURSEMENT OF THE MEDICAL PLAN**

(This Article does not apply to any HMO options or fully insured PPO options set forth in the Benefit Description)

Section 11.01 Subrogation/Reimbursement Rights of the Medical Plan.

- (A) **Medical Plan's Right to Subrogation.** The Medical Plan shall be subrogated to all rights that a Participant, covered Dependent, or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, worker's compensation or any other occupational disease act or law, uninsured motorist coverage, and business/homeowners medical liability insurance coverage or payments) or other entity with respect to *any and all benefits* previously paid by the Medical Plan, or on behalf of the Medical Plan, to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.
- (B) **Medical Plan's Right to Reimbursement.** A Participant, covered Dependent, or assignee agrees to include the amounts of any and all benefits paid by the Medical Plan (or any amount considered to be for future medical expenses) in any Claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by a Participant, covered Dependent, or assignee from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the Medical Plan shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the Medical Plan.

Section 11.02 Amount of Recovery. The Medical Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Medical Plan. The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a Claim or reimbursement. In addition, these rights take priority over the Participant's, covered Dependent's, or assignee's right to be made whole.

Section 11.03 Condition of Payment. By accepting benefits from the Medical Plan, a Participant, covered Dependent, or his/her assignee agrees to the following:

- (A) The Medical Plan may require a Participant, covered Dependent, assignee, or someone legally qualified and authorized to act for such person, to agree to the provisions in this Medical Plan, Sections 11.01 and 11.03 in writing, and execute any and all other instruments reasonably necessary for the Medical Plan to assert its rights under these Sections; and
- (B) Any amounts recovered by such individual or by the Medical Plan by judgment, settlement, or otherwise will be applied first to reimburse the Medical Plan; and
- (C) The Medical Plan shall be subrogated to all Claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Medical Plan; and

- (D) At the Medical Plan's request, a Participant, covered Dependent, or assignee must take any action, give information, and/or execute instruments required by the Medical Plan, in its discretion, in order to aid the Medical Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the Medical Plan may withhold benefits, services, payments, or credits due under the Medical Plan.

ARTICLE XII
TERMINATION AND AMENDMENT OF THE MEDICAL PLAN

Section 12.01 Termination and Amendment. The Plan Sponsor Committee may amend or terminate this Medical Plan at any time in accordance with the procedures established by the Administrative Agreement, which procedures are hereby incorporated by reference. Any approved change to the Medical Plan shall be made through a written instrument. Upon termination of this Medical Plan, the Employer shall give notice of the termination to all Participants, all individuals then receiving benefits under this Medical Plan, and any other affected person.

ARTICLE XIII MISCELLANEOUS

Section 13.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 13.02 Employment Not Guaranteed. Nothing contained in this Medical Plan or any modification or amendment to this Medical Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Medical Plan.

Section 13.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any individual employed by an Employer who is carrying out his/her responsibilities within the scope of his/her job duties and to whom fiduciary responsibility with respect to this Medical Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Medical Plan or under his/her job duties related to this Medical Plan. This indemnification does not cover such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person, provided this paragraph shall not limit any indemnification of the Employee pursuant to any indemnification provisions of the bylaws of the Employer of the Employee or pursuant to any indemnification insurance held by such employer.

Section 13.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Medical Plan.

Section 13.05 Legal Service. Process can be served on the Medical Plan by directing such legal service to the Claims Administrator and/or the Plan Administrator.

Section 13.06 Limitation of Rights. Neither the establishment of this Medical Plan, nor any amendment, nor the payment of any benefit gives any Participant or any other person a legal or equitable right against the Employer or the Plan Administrator, nor any rights of continued employment.

Section 13.07 Limitation on Liability. A Medical Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Medical Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 13.08 Named Fiduciary. The named fiduciary of this Medical Plan shall be the Farm Credit Foundations Trust Committee (“Trust Committee”). The Trust Committee shall have complete authority to control and manage the operation and administration of this Medical Plan. If so designated in a contract between the Trust Committee and a Claims Administrator, the Claims Administrator shall also be a named fiduciary of this Medical Plan to the extent designated in such contract. In addition, the Insurer providing and making benefit payments for a particular insured benefit shall be named fiduciary of this Medical Plan with respect to that benefit.

Section 13.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Medical Plan will be excludable from the Participant’s gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Medical Plan is excludable from the Participant’s gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Section 13.10 Nonalienation of Benefits. Benefits payable under this Medical Plan are not subject in any manner to transfer or assignment, unless such benefits are transferred or assigned (a) for the purpose of providing payment for services provided under the terms of this Medical Plan, and/or (b) as expressly permitted under the terms of this Medical Plan; any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Medical Plan, is void. The Employer is not in any manner liable for, nor subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Medical Plan.

Section 13.11 Prohibition Against Retroactive Entry into the Medical Plan. In the event that a person was determined to be ineligible to participate in the Medical Plan due to the person’s classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Medical Plan on a prospective basis only. Except as may be required in connection with the Medical Plan’s voluntary compliance with HIPAA special enrollment rights, no person shall be allowed to enter the Medical Plan on a retroactive basis.

Section 13.12 Rights to Employer’s Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Medical Plan, and then only to the extent of the benefits payable under the Medical Plan to such Participant or beneficiary. The Employer will make all payments of benefits this Medical Plan provides solely from the assets of the Employer, and the Plan Administrator is not liable for payment of benefits in any manner.

Section 13.13 Source of Funds. The Medical Plan shall be funded by direct payments from the Farm Credit Foundations Welfare Benefit Trust. The trust shall be funded by the Employer and voluntary Employee compensation reductions subject to all of the provisions of this Medical Plan.

Section 13.14 State Law. The laws of the state of Delaware will determine all questions arising with respect to the provisions of this Medical Plan except to the extent superseded by Federal law.

**BENEFIT DESCRIPTION
FOR THE FARM CREDIT FOUNDATIONS MEDICAL PLAN**

The medical care benefits offered under the Medical Plan are described in this Benefit Description and attached Benefit Schedules and are provided pursuant to Section 5.01 of the Wrap Around Plan Document. This Benefit Description is a part of and incorporated into the Wrap Around Plan Document of the Medical Plan. This Benefit Description incorporates by reference the terms and conditions of each benefit option listed below and set forth in an attached Benefit Schedule.

All Eligible Employees and Eligible Disabled Persons may choose to participate in one of the following three self-funded benefit options:

Premium PPO Option Benefit Schedule A
(Group Nos. 016772 & 016775)

Standard PPO Option
(Group Nos. 016773 & 016776)..... Benefit Schedule B

Consumer Choice PPO Option Benefit Schedule C
(Group Nos. 016774 & 016777)

In addition, depending on the Eligible Employee's or Eligible Disabled Person's state of residency, he/she may participate in one of the following fully insured benefit options instead of one of the above-listed self-funded benefit options:

Residents of Hawaii:

HMSA PPO Option Benefit Schedule D
(Group No. 72769-1-8 Package: 001)

Hawaii Medical Service Association ("HMSA") HMO Option Benefit Schedule E
(Group No. 72769-1-8 Package: 002)

Residents of California:

Blue Cross of California HMO option
Effective April 1, 2008, **Anthem Blue Cross Life and Health**..... Benefit Schedule F
(Policy Nos. 59Q90A & L, 56AYKA & B, and 59Q90B)

Residents of Utah:

SelectHealth Health Plan..... Benefit Schedule G
(Policy No. G1006685)

Participants and their covered Dependents will only receive benefits under the benefit option in which they are enrolled, according to the terms and conditions of the applicable Benefit Schedule. However, unless otherwise provided in the Wrap Around Plan Document, the following provisions are addressed in the Wrap Around Plan Document and not in the applicable Benefit Schedules:

- Definitions not contained in the benefit option
- Eligibility and participation in the Medical Plan
- Time and duration of coverage
- Continuation of coverage
- HIPAA medical privacy
- Plan Administration
- Claims procedures
- Subrogation/Reimbursement rights of the Medical Plan
- Termination and amendment of the Medical Plan
- Other miscellaneous provisions