

**FARM CREDIT FOUNDATIONS
FLEXIBLE BENEFITS PLAN**

Effective January 1, 2007

TABLE OF CONTENTS

PREAMBLE

ARTICLE I, INTRODUCTION

Section 1.01	Purpose of Plan	1.1
Section 1.02	Cafeteria Plan Status.....	1.1
Section 1.03	Single Employer Plan Status	1.1
Section 1.04	Exclusive Benefit	1.1
Section 1.05	Effect on Prior Plans.....	1.1
Section 1.06	Effective Date	1.2
Section 1.07	Required Forms.....	1.2

ARTICLE II, DEFINITIONS

Section 2.01	After-Tax Benefits.....	2.1
Section 2.02	Annual Enrollment Period.....	2.1
Section 2.03	Benefit Package Option.....	2.1
Section 2.04	Claims Administrator	2.1
Section 2.05	Code	2.1
Section 2.06	Compensation	2.1
Section 2.07	Dependent	2.1
Section 2.08	Dependent Care Assistance Plan or DCAP	2.3
Section 2.09	Election Change Event	2.3
Section 2.10	Eligible Employee	2.3
Section 2.11	Employee.....	2.4
Section 2.12	Employer	2.5
Section 2.13	Flexible Benefits Plan	2.5
Section 2.14	FMLA	2.5
Section 2.15	Health Flexible Spending Account or Health FSA	2.5
Section 2.16	HIPAA.....	2.5
Section 2.17	Insurance Company or Insurance Companies	2.5
Section 2.18	Insured Benefit	2.5
Section 2.19	Participant.....	2.5
Section 2.20	Plan Administrator	2.5
Section 2.21	Plan Year	2.5
Section 2.22	Pre-Tax Benefits.....	2.6
Section 2.23	Pre-Tax Component Plan	2.6
Section 2.24	Regular Full-Time Employee	2.6
Section 2.25	Regular Part-Time Employee	2.6
Section 2.26	Severance Period	2.6
Section 2.27	Schedule of Service Providers	2.6
Section 2.28	USERRA.....	2.7
Section 2.29	Spouse	2.7
Section 2.30	Welfare Benefits	2.7

ARTICLE III, ELIGIBILITY AND PARTICIPATION

Section 3.01	Eligibility to Participate.....	3.1
Section 3.02	Termination of Participation.....	3.2
Section 3.03	Cessation of Election to Receive Coverage or Benefits	3.3
Section 3.04	Family and Medical Leave Act of 1993.....	3.4
Section 3.05	Other Approved Paid Leaves	3.5
Section 3.06	Other Approved Unpaid Leaves	3.5

ARTICLE IV, OPTIONAL BENEFITS

Section 4.01	Pre-Tax Benefit Choices.....	4.1
Section 4.02	Taxable Benefit Choices.....	4.2

ARTICLE V, ELECTION OF BENEFITS

Section 5.01	Election of Benefits	5.1
Section 5.02	Election Procedure	5.1
Section 5.03	New Participants.....	5.1
Section 5.04	Absence of Election.....	5.2
Section 5.05	Election is Irrevocable	5.2
Section 5.06	Election Change Due to Change in Status	5.2
Section 5.07	Election Change Due to Exercise of HIPAA Special Enrollment Rights	5.4
Section 5.08	Election Change Due to Change in Coverage.....	5.6
Section 5.09	Election Change Due to FMLA Leave	5.8
Section 5.10	Election Change Due to Issuance of Judgment, Decree, or Order	5.8
Section 5.11	Election Change Due to Medicare/Medicaid Entitlement	5.8
Section 5.12	Election Change Required by the Plan Administrator	5.9
Section 5.13	Election Change Due to Significant Change in Cost	5.9
Section 5.14	Automatic Election Change for Insignificant Changes in Cost	5.10
Section 5.15	Requesting and Approving Election Changes	5.10
Section 5.16	Effective Date of Election Changes	5.10
Section 5.17	Elections of Former Participants Rehired Within One Month of Termination.....	5.11
Section 5.18	Special Election Change Rule for Pre-Tax Component Plans	5.11
Section 5.19	Maximum Benefits	5.11

ARTICLE VI, CLAIMS ADMINISTRATION

Section 6.01	Claims Administrators.....	6.1
Section 6.02	Duties of the Claims Administrator	6.1
Section 6.03	Claims Procedure	6.2
Section 6.04	Health FSA and DCAP – Claims Denial	6.3
Section 6.05	Health FSA and DCAP – Appeal of Claim Denial to Claims Administrator	6.3
Section 6.06	Health FSA and DCAP – Coordination of Benefits.....	6.4
Section 6.07	Health FSA and DCAP – Electronic Payment Card Reimbursements ...	6.4
Section 6.08	Litigation of Claim	6.4

ARTICLE VII, PLAN ADMINISTRATION

Section 7.01	Plan Administrator	7.1
Section 7.02	Plan Must Be Nondiscriminatory	7.1

ARTICLE VIII, TERMINATION AND AMENDMENT OF THE PLAN

Section 8.01	Termination and Amendment	8.1
--------------	---------------------------------	-----

ARTICLE IX, MISCELLANEOUS

Section 9.01	Construction	9.1
Section 9.02	Employment Not Guaranteed	9.1
Section 9.03	Indemnification	9.1
Section 9.04	Information.....	9.1
Section 9.05	Legal Service.....	9.1
Section 9.06	Limitation of Rights	9.1
Section 9.07	Limitation on Liability	9.1
Section 9.08	Named Fiduciary	9.2
Section 9.09	No Guarantee of Tax Consequences	9.2
Section 9.10	Nonalienation of Benefits.....	9.2
Section 9.11	Prohibition Against Retroactive Entry into the Plan	9.2
Section 9.12	Rights to Employer's Assets.....	9.2
Section 9.13	Source of Funds	9.2
Section 9.14	State Law.....	9.3

SCHEDULE OF SERVICE PROVIDERS HSA MAXIMUM CONTRIBUTION LIMIT SCHEDULE

APPENDICES

Appendix A, Health Flexible Spending Account

Article A-1, Medical Reimbursement

Section A1.01	Selection of Coverage Option.....	A-1
Section A1.02	Qualified Medical Expense	A-1
Section A1.03	Reimbursement of Qualified Medical Expenses	A-2
Section A1.04	Maximum Amount of Reimbursement	A-3
Section A1.05	Withholding – Accounting	A-3
Section A1.06	Year End Accounting – Forfeitures.....	A-3
Section A1.07	Payment of Medical Expenses	A-3
Section A1.08	Limitation on Reimbursements With Respect to Certain Participants.....	A-4
Section A1.09	HSA and Health FSA.....	A-4
Section A1.10	Claims Procedures	A-4

Article A-II, Termination of Participation in the Health FSA

Section A2.01	Termination of Participation in Health FSA Benefit.....	A-5
Section A2.02	Continuation of Coverage (Other than USERRA).....	A-5
Section A2.03	Limits on Continuation Coverage	A-5
Section A2.04	USERRA Continuation Rights	A-6
Section A2.05	Electronic Payment Card.....	A-6
Section A2.06	Qualified Reservist Distributions (“QRD”).....	A-6
Section A2.07	Amount of the QRD	A-6
Section A2.08	Time Frame for Requesting a QRD.....	A-6
Section A2.09	Time Frame for Plan Administrator to Respond to a Request for a QRD	A-6
Section A2.10	Eligible Claims	A-7
Section A2.11	No Penalty on QRD	A-7
Section A2.12	Effective Date	A-7

Article A-III, HIPAA Medical Privacy and Security Amendments

Part I- Preamble

Section A3.01	Purpose and Effective Date.....	A-7
Section A3.02	Application of Amendment.....	A-7
Section A3.03	Relationship to Other Group Health Plans	A-7
Sections A3.04 - A3.10	RESERVED	

Part II- Disclosure of PHI to the Employer

Section A3.11	Prohibition Against Disclosing Protected Health Information to the Employer	A-8
Section A3.12	Definitions.....	A-8
Section A3.13	Enrollment/Disenrollment Information	A-10
Section A3.14	Plan Administration Functions	A-10
Section A3.15	Conditions for Disclosure for Plan Administration Functions.....	A-12
Section A3.16	Certification by the Employer.....	A-13
Sections A3.17-A3.20	RESERVED	

Part III- Administrative Safeguards

Section A3.21	Adequate Separation Between the Employer and the Plan	A-14
Section A3.22	Authorized Employees.....	A-14
Section A3.23	Use Pursuant to an Authorization.....	A-14
Section A3.24	Consequences of Unauthorized Use of PHI or e-PHI.....	A-15

Appendix B, Dependent Care Assistance Plan

Article B-I, Dependent Care Reimbursement

Section B1.01	Qualified Dependent Care Expense	B-1
Section B1.02	Reimbursement of Qualified Dependent Care Expenses	B-2
Section B1.03	Maximum Amount of Reimbursement	B-2
Section B1.04	Withholding – Accounting	B-2
Section B1.05	Year End Accounting – Forfeitures.....	B-3
Section B1.06	Payment of Qualified Dependent Care Expenses	B-3
Section B1.07	Limitation on Reimbursements With Respect to Certain Participants.....	B-3

Article B-II, Termination of DCAP Coverage

Section B2.01 Termination of Participation in DCAP Benefit.....B-4

Appendix C, Vision Plan

Section C1.01 Eligibility..... C-1
Section C1.02 Vision Insurance Coverage C-1
Section C1.03 Election to Participate..... C-1
Section C1.04 USERRA Continuation Rights C-1
Section C1.05 Continuation of Coverage (other than USERRA) C-2

Appendix D, Cancer Plan

[RESERVED]

Appendix E, Voluntary Accidental Death and Dismemberment Insurance Plan

Section E1.01 Voluntary Accidental Death and Dismemberment Insurance Plan.....E-1
Section E1.02 Election to Participate.....E-1

Appendix F, Optional Basic Life / Accidental Death & Dismemberment Insurance Plan

Section F1.01 Optional Basic Life / AD&D Insurance Plan.....F-1
Section F1.02 Election to Participate.....F-1

Appendix G, Group Universal Life Insurance Plan

Section G1.01 Group Universal Life Insurance Plan..... G-1
Section G1.02 Election to Participate..... G-1

Appendix H, Health Savings Account

Section H1.01 Eligibility..... H-1
Section H1.02 High Deductible Health Plan Coverage H-1
Section H1.03 Effective Date of Election H-1
Section H1.04 HSA Benefits H-1
Section H1.05 Carryover of Unused Amounts H-2
Section H1.06 Funding of HSA H-2
Section H1.07 Election Changes H-2
Section H1.08 HSA and Health FSA..... H-2
Section H1.09 Maximum Annual Contribution Limit..... H-2
Section H1.10 Recording Contributions for HSA H-3
Section H1.11 HSA Providers H-3
Section H1.12 Trust/Custodial Agreement..... H-3
Section H1.13 Tax Treatment of HSA Contributions and Distributions..... H-3

Appendix I, Child Term Life Insurance Plan

Section I1.01 Child Term Life Insurance Plan I-1
Section I1.02 Election to Participate..... I-1

FARM CREDIT FOUNDATIONS FLEXIBLE BENEFITS PLAN

PREAMBLE

The Farm Credit Foundations Flexible Benefits Plan (the “Flexible Benefits Plan”) is sponsored and maintained by AgriBank, FCB (“AgriBank”) and by U.S. AgBank, FCB (“U.S. AgBank”) for the benefit of the eligible employees of each Bank, their affiliated associations, Northwest Farm Credit Services, and other employers within the federal Farm Credit System who are parties to the Farm Credit System Administrative Agreement Regarding Employee Benefit Plans (“Administrative Agreement”). The Flexible Benefits Plan is intended to conform to and qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder.

Participation in this Flexible Benefits 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); 12 U.S.C. § 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 Flexible Benefits Plan is intended to be a “governmental plan” as that term is defined in Code § 414(d). As a “governmental plan,” the Flexible Benefits Plan is not subject to Title I of the Employee Retirement Income Security Act of 1974 (“ERISA”). In addition, the Flexible Benefits 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 Flexible Benefits Plan. Because of the close relationship that exists between the employers in the Flexible Benefits 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 Flexible Benefits Plan, consistent with prior historical practice, is designed and intended to be a single employer plan.

ARTICLE I INTRODUCTION

Section 1.01 Purpose of Plan. The purpose of this Flexible Benefits Plan is to provide eligible Employees of the Employer a choice between taxable compensation, pre-tax benefits and after-tax benefits offered by the Employer.

Section 1.02 Cafeteria Plan Status. It is the intent of the Employer that this Flexible Benefits Plan qualify as a “cafeteria plan” within the meaning of Code § 125 and, to the maximum extent possible, that any benefits paid under the Flexible Benefits Plan be eligible for exclusion from gross income under Code §§ 105, 106 and 129. As a “cafeteria plan,” the Internal Revenue Service views contributions to pay for one or more benefits under the Flexible Benefits Plan which come from an Eligible Employee’s earnings as Employer contributions. The Employer presently provides, and may continue to provide, a variety of other employee benefits to some or all of its employees on a non-elective basis. The benefits provided under this Flexible Benefits Plan shall be in addition to and not in lieu of such other benefits. Such other benefits shall not constitute a part of this Flexible Benefits Plan.

Section 1.03 Single Employer Plan Status. In light of this Flexible Benefits Plan’s status as a “governmental plan,” it is the intent of the Employer that this Flexible Benefits Plan be considered a single employer plan.

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

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, these Farm Credit System employers agreed to consolidate certain employee benefit plans previously sponsored separately. Effective January 1, 2007, this Flexible Benefits Plan amends and restates the flexible benefit plans, the After-Tax Benefits listed in Section 2.01, and the Pre-Tax Benefits listed in Section 2.22 that were previously sponsored by these Farm Credit System employers. As part of this amendment and restatement, the name of the Flexible Benefits Plan is changed to the Farm Credit Foundations Flexible Benefits Plan.

Except for the Farm Credit Foundations Medical Plan and the Farm Credit Foundations Dental Plan, the Welfare Benefits (as that term is defined in Section 2.30) have been combined into this Flexible Benefits Plan document through this amendment and restatement. Separate plan documents have been eliminated for all welfare benefits provided on an after-tax or pre-tax basis. However, the Farm Credit Foundations Medical Plan and the Farm Credit Foundations Dental Plan continue to be governed by separate plan documents, which are incorporated into this Flexible Benefits Plan document by reference. In addition, pre-tax benefits entirely paid with Employer contributions are governed by the terms and conditions of the Farm Credit Foundations Employer Provided Welfare Benefits Plan, which is also a separate plan document.

Section 1.06 Effective Date. The Effective Date of this Flexible Benefits Plan, as amended and restated, is January 1, 2007; provided, however, that if this Flexible Benefits Plan is subsequently amended, such new or amended provisions shall be effective on a later date as provided in the Farm Credit Foundations Plan Sponsor Committee minutes adopting such new or amended provisions.

Section 1.07 Required Forms. The Plan Administrator may require the completion and submission of any form required pursuant to this Flexible Benefits Plan (e.g., change in status form) 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

Section 2.01 “**After-Tax Benefits**” means any one or more of the following benefits:

- (A) Farm Credit Foundations Group Universal Life Insurance Plan (“Group Universal Life Insurance Plan”);
- (B) Farm Credit Foundations Child Term Life Insurance Plan (“Child Term Life Insurance Plan”); or
- (C) Farm Credit Foundations Optional Basic Life / Accidental Death & Dismemberment Insurance Plan (“Optional Basic Life / Accidental Death & Dismemberment Insurance Plan”), but only to the extent the group term life insurance coverage provided thereunder exceeds \$50,000 when such coverage is combined with the group term life insurance coverage under the Farm Credit Foundations Basic Life Plan.

Section 2.02 “**Annual Enrollment Period**” means the period designated by the Plan Administrator at least thirty (30) days prior to the beginning of each Plan Year, during which period Participants are allowed to make elections with respect to the following Plan Year.

Section 2.03 “**Benefit Package Option**” means a coverage option that is offered under a Pre-Tax Benefit or a Pre-Tax Component Benefit Plan. For example, a “high deductible” or “low deductible” health plan option under the Farm Credit Foundations Medical Plan would be a Benefit Package Option.

Section 2.04 “**Claims Administrator**” means the Plan Administrator, unless, pursuant to Article VI, a different Claims Administrator has been specifically named with the authority to grant or deny claims for benefits.

Section 2.05 “**Code**” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.06 “**Compensation**” means wages, salary and other remuneration paid to a Participant of the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or 403(b) plan or arrangements on behalf of the Participant, or any other deferred compensation plan maintained by the Employer. “Compensation” also does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.07 “**Dependent**” means:

- (A) **Spouse.** The Participant’s Spouse who is not divorced or legally separated from the Participant; or
- (B) **Domestic Partner.** The Participant’s Domestic Partner. A Domestic Partner means a person of the same or opposite sex for whom each of the following conditions is met:

- (1) **Age Requirement.** The Participant and the person are at least age eighteen (18); and
 - (2) **Consent to Contract.** The Participant and the person have attained the legal age to consent to contract according to the laws of the state in which they reside; and
 - (3) **No Blood Relationship.** The Participant and the person are not related by blood in a degree that is closer than what would be permitted in the state in which they reside if the person and the Participant desired to be married; and
 - (4) **Cohabitation.** The Participant and the person have lived together for at least six (6) consecutive months in an exclusive committed relationship of mutual caring and support and plan to continue their relationship indefinitely; and
 - (5) **No Other Marriage or Domestic Partnership.** Neither the person nor the Participant is married to any other person, any prior marriages involving the person and/or the Employee or the Disabled Person have been legally dissolved, the relationship between the person and the Employee or the Disabled Person is exclusive, and there is no other person who is a spousal equivalent or Domestic Partner of either the person or the Employee or the Disabled Person; and
 - (6) **Common Welfare and Financial Obligations.** The Participant and the person are jointly responsible for each other's common welfare and share financial obligations.
- (C) **Tax Dependent.** A tax dependent of the Participant as defined in Code § 152, except as follows:
- (1) Pre-Tax Component Plans / Vision Plan / Health Flexible Spending Account. For purposes of participating in the Pre-Tax Component Plans, the Vision Plan and the Health Flexible Spending Account,
 - (a) A dependent is defined as in Code § 152 without regard to subsections (b)(1), (b)(2), and (d)(1)(B) of Code § 152; and
 - (b) Any child to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and who are in the custody of one or both parents for more than half of the calendar year) is treated as a dependent of both parents.
 - (2) Dependent Care Assistance Plan. For purposes participating in the Dependent Care Assistance Plan, a dependent means a Qualifying Individual as defined in Section B1.01(C) of Appendix B of this Plan.

A Domestic Partner who is a tax dependent of the Participant as defined in this Section 2.07(C) is not a Dependent for purposes of participation *on a pre-tax basis* in the Pre-Tax Component Plans or the Pre-Tax Benefits. An eligible Domestic Partner of a Participant may only participate in these benefits on an after-tax basis.

Section 2.08 “Dependent Care Assistance Plan” or “DCAP” means an account established on behalf of a Participant in accordance with Section 4.01(B) of this Flexible Benefits Plan.

Section 2.09 “Election Change Event” means an event which would allow a Participant to change the Participant’s elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.14.

Section 2.10 “Eligible Employee” means a Regular Full-Time Employee or a Regular Part-Time Employee, subject, however, to the following:

(A) **Status During Leaves of Absence.**

(1) Up to Six Months of Leave of Absence. 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. However, an Employee’s status as an Eligible Employee shall cease on the last day of active employment for purposes of participation in the Farm Credit Foundations Voluntary AD&D Insurance Plan.

(2) Leave of Absence Greater than Six Months. An Employee’s status as an Eligible Employee shall be deemed to continue during any leave of absence approved by the Employer which is greater than six (6) months, subject to the limitations below:

(a) **Pre-Tax Component Plans / Vision Plan.**

(i) Military Leave. Coverage may continue under one or more of the Pre-Tax Component Plans and the Farm Credit Foundations Vision Plan for approved military leaves in accordance with USERRA, as set forth in the Pre-Tax Component Plans and in the Farm Credit Foundations Vision Plan, as applicable.

(ii) Long Term Disability Leave. Coverage may continue under the Farm Credit Foundations Vision Plan for leaves taken pursuant to the Farm Credit Foundations Long Term Disability Plan until the earlier of the Participant’s normal retirement age,

the end of the month coincident with or next following the date of the Participant's retirement, or the date on which the Participant is no longer eligible for long term disability benefits.

- (b) **Health Flexible Spending Account / Dependent Care Assistance Plan / Health Savings Account.** Coverage may continue under the Health FSA and the DCAP through the end of the calendar year in which the approved leave begins. Contributions to a Health Savings Account may also continue through the end of the calendar year in which the approved leave begins.
 - (c) **Farm Credit Foundations Optional Basic Life / Accidental Death & Dismemberment Insurance Plan and the Farm Credit Foundations Child Term Life Insurance Plan.** Coverage may continue for basic life insurance and dependent life insurance under the Optional Basic Life / Accidental Death & Dismemberment Insurance Plan and the Child Term Life Insurance Plan if the Participant is deemed disabled pursuant to the Long Term Disability Plan and is receiving benefits under such Long Term Disability Plan.
- (B) **Ineligible Persons Under the Code.** For purposes of participating in this Flexible Benefits Plan, the term "Eligible Employee" shall not include any individual who is, with respect to the Employer, self-employed within the meaning of Code § 401(c)(1) or treated as a partner under Code § 1372.
 - (C) **Additional Eligibility Requirements for Certain Benefits.** The Pre-Tax Benefit Plans may have additional eligibility requirements. Such additional requirements, if any, are set forth separately in this Flexible Benefits Plan document.

Section 2.11 "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.
- (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).

- (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. A Part-Time Without Benefits Employee is not an Employee for purposes of participation in the Flexible Benefits Plan and, therefore, is not eligible to participate in the Flexible Benefits Plan.

Section 2.12 “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 Flexible Benefits 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 Flexible Benefits Plan.

Section 2.13 “Flexible Benefits Plan” means the Farm Credit Foundations Flexible Benefits Plan.

Section 2.14 “FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.15 “Health Flexible Spending Account” or “Health FSA” means an account established on behalf of a Participant in accordance with Section 4.01(A) of this Flexible Benefits Plan.

Section 2.16 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.17 “Insurance Company” or “Insurance Companies,” collectively, means any insurance carrier which provides insurance and has the responsibility for providing and making benefit payments for any of the Pre-Tax Benefits and After-Tax Benefits.

Section 2.18 “Insured Benefit” is a Pre-Tax Benefit or After-Tax Benefit which is provided through a contract between the Farm Credit Foundations Plan Sponsor Committee and an Insurance Company.

Section 2.19 “Participant” means an Employee who has met the requirements for eligibility and who participates in this Flexible Benefits Plan in accordance with Article III. In addition, a Participant means a former Employee who is permitted to continue participation in the Flexible Benefits Plan pursuant to Section 3.02.

Section 2.20 “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 Flexible Benefits Plan in a manner consistent with the terms of this Flexible Benefits Plan.

Section 2.21 “Plan Year” means the fiscal year of the Flexible Benefits Plan, a twelve (12) consecutive month period ending every December 31.

Section 2.22 “**Pre-Tax Benefits**” means any of the following benefits:

- (A) Farm Credit Foundations Health Flexible Spending Account (“Health FSA”);
- (B) Farm Credit Foundations Dependent Care Assistance Plan (“DCAP”);
- (C) Farm Credit Foundations Vision Plan (“Vision Plan”);
- (D) Farm Credit Foundations Voluntary AD&D Insurance Plan (“Voluntary AD&D Insurance Plan”); or
- (E) Farm Credit Foundations Optional Basic Life / Accidental Death & Dismemberment Insurance Plan (“Optional Basic Life / Accidental Death & Dismemberment Insurance Plan”), to the extent the group term life insurance coverage provided thereunder does not exceed \$50,000 when such coverage is combined with the group term life insurance coverage under the Farm Credit Foundations Basic Life Plan.

In addition, the term “Pre-Tax Benefits” also includes contributions made by a Participant on a pre-tax basis to a Health Savings Account (“HSA”).

Section 2.23 “**Pre-Tax Component Plan**” means any of the following plans:

- (A) Farm Credit Foundations Medical Plan; or
- (B) Farm Credit Foundations Dental Plan.

Section 2.24 “**Regular Full-Time Employee**” means an Employee who is regularly scheduled to work at least thirty-two (32) hours per week. 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 the Family and Medical Leave Act of 1993 (“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 thirty-two (32) hours per week. 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 pursuant to an agreement, plan, or policy of the Employer providing such Compensation to Employees whose employment has been involuntarily terminated.

Section 2.27 “**Schedule of Service Providers**” means the schedule attached to and made a part of this Flexible Benefits Plan, which sets forth the current service providers for certain benefits provided through this Flexible Benefits Plan.

Section 2.28 “**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.29 “**Spouse**” means a person of the opposite sex to whom the Participant is legally married. A common law marriage to a person of the opposite sex shall be considered to be a legal marriage if the common law marriage was entered into in a state that recognizes common law marriage and if the common law marriage is recognized as valid under the laws of that state. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of legal marriage (including, as may be applicable, the existence of a common law marriage).

Section 2.30 “**Welfare Benefits**” means one or more benefits under a Pre-Tax Component Plan, the Pre-Tax Benefits and/or the After-Tax Benefits under this Flexible Benefits Plan.

**ARTICLE III
ELIGIBILITY AND PARTICIPATION**

Section 3.01 Eligibility to Participate. An Eligible Employee becomes a Participant on the first day of the pay period coincident with or next following his/her date of hire. An Eligible Employee who has entered into the Flexible Benefits Plan under this Section 3.01 is a Participant without regard to whether he/she elects to reduce his/her Compensation in order to purchase benefits under one or more of the Pre-Tax Benefits.

- (A) **Transferees.** An Employee directly transferring from another Farm Credit System Employer will become a Participant in the Flexible Benefits Plan on his/her date of hire.
- (B) **Rehired Participants.** As a general rule, if a Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant will again become a Participant in the Flexible Benefits Plan pursuant to the provisions of this Section 3.01. However, if a Participant is rehired during the same Plan Year in which the Participant terminates employment, the Participant shall become a Participant in the Flexible Benefits Plan and his/her former Pre-Tax Benefit elections shall be reinstated on the first day of the pay period coincident or next following his/her date of hire. The Participant's After-Tax Benefit elections shall be reinstated in accordance with the terms and conditions of the After-Tax Benefits. The elections of a former Participant who reenters the Flexible Benefits Plan within thirty (30) days after the date on which he/she ceased to be a Participant are subject to the provisions of Section 5.17.
- (C) **Employees of Affiliating Employers.** In the case of any Employee of a Farm Credit System Employer that affiliates with AgriBank or U.S. AgBank and becomes an Employer under this Flexible Benefits Plan in accordance with Section 2.12 of this Flexible Benefits Plan, such Employee will become a Participant as provided in the affiliation agreement entered into between AgriBank or U.S. AgBank and such Farm Credit System Employer.
- (D) **Employees Changing Classification Status.** An Employee whose classification status changes from a Part-Time Without Benefits Employee, as defined in Section 2.11(C), to Regular Part-Time Employee or Regular Full-Time Employee will become a Participant in the Flexible Benefits Plan on the first day of the pay period coincident with or next following the change in classification status.
- (E) **Exception for New Hires in December 2006.** Eligible Employees of U.S. AgBank and its affiliated associates whose date of hire is December 2006 shall be eligible for the Flexible Benefits Plan on January 1, 2007.

Section 3.02 Termination of Participation.

(A) **General Rule.** A Participant will cease participation in the Flexible Benefits Plan on the earliest of:

- (1) The date on which the Flexible Benefits Plan terminates;
- (2) The date on which the Participant terminates employment with the Employer;
- (3) The date on which the Employer's participation in the Administrative Agreement is terminated; or
- (4) The date on which the Participant is no longer an Eligible Employee under the Plan.

After the employment relationship has terminated, and except as otherwise expressly provided in Subsection (B), employment with the Employer will not include any period of time for which the Employer compensates the Employee but during which the Employee does not perform any service for the Employer. For this purpose, "period of time" includes, without limitation, vacation, holiday, sick leave, illness, incapacity (including disability), layoff, jury duty, or military duty.

(B) **Special Rule for Participants in their Severance Period.** A Participant who is receiving Compensation from the Employer pursuant to an agreement, plan, or policy of the Employer providing such Compensation to Employees whose employment has been involuntarily terminated may continue to participate in the Flexible Benefits Plan for the limited purpose of reducing his/her Compensation and having the amount of Compensation so reduced applied by the Employer toward the cost of benefits available under one or more of the Pre-Tax Component Plans and/or the Vision Plan until the earliest of:

- (1) The date on which the Flexible Benefits Plan terminates;
- (2) The date on which the Participant is no longer eligible to participate in at least one of the Pre-Tax Component Plans or in the Vision Plan, as applicable;
- (3) The date on which the Participant's Severance Period ends; or
- (4) The end of the eighteen-month period following in which the first severance payment is made.

In no event may such continued participation result in the impermissible deferral of the receipt of Compensation (as provided under the Code) from the Plan Year in which such Compensation was made available to the Participant to a subsequent Plan Year.

Section 3.03 Cessation of Election to Receive Coverage or Benefits.

- (A) **General Rule.** Unless otherwise provided in the Pre-Tax Benefits or After-Tax Benefits, a Participant's election to receive a Pre-Tax Benefit or After-Tax Benefit will cease on the earliest of the following:
- (1) The date on which participation in the Flexible Benefits Plan terminates under Section 3.02 of this Flexible Benefits Plan (however, such coverage may continue through the end of the pay period in which the termination of employment occurs if provided in the underlying Pre-Tax Benefit or After-Tax Benefit);
 - (2) The date on which the Participant's election to receive the benefit expires;
 - (3) The date on which the Employer amends the Flexible Benefits Plan to eliminate the benefit; or
 - (4) The end of a period for which a required Employee contribution was last paid by the Participant.

Although a Participant's participation under this Flexible Benefits Plan terminates on the above date, coverage or benefits under the Pre-Tax Benefits or After-Tax Benefits may continue if and to the extent provided by such Pre-Tax or After-Tax Benefits.

- (B) **Special Rule for Pre-Tax Component Plans.** Termination of coverage under a Pre-Tax Component Plan is governed by the terms and conditions of such plan. If a Participant's participation under this Flexible Benefits Plan terminates under Section 3.02 of this Flexible Benefits Plan, coverage or benefits under the Pre-Tax Component Plans may continue if and to the extent provided by such Pre-Tax Component Plans.
- (C) **Special Rule for Decreasing/Revoking Coverage Under a Pre-Tax Benefit.** If a Participant does not timely notify the Employer of an event which permits the Participant to decrease or revoke his/her election, the Participant's election to receive one or more Pre-Tax Benefits shall remain in effect despite the Participant's and/or the Participant's Dependent's loss of coverage under such Pre-Tax Benefit.

Section 3.04 Family and Medical Leave Act of 1993. This Section 3.04 applies only to those Participants who are entitled to leave under FMLA.

- (A) **General Rule.** Notwithstanding any provision to the contrary in this Flexible Benefits Plan, and except as otherwise provided in Section 3.04(D), if a Participant goes on a qualifying unpaid leave under FMLA, the Employer will, to the extent required by FMLA, continue to maintain the Participant's benefits under a group health plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). Additional rules may apply to the Participant's coverage under the Health FSA as stated in Appendix A of this Flexible Benefits Plan.
- (B) **Options for Payment of Participant's Share of the Premium.** If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one of the following ways:
- (1) The Participant may pay his/her share of the premium with pre-tax dollars to the extent the Employee receives Compensation during the leave;
 - (2) The Participant may be given the option to pre-pay all or a portion of his/her share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his/her pre-leave Compensation by making a special election to that effect prior to the date such Compensation would normally be made available to the Participant. The Participant may not, however, use pre-tax dollars during the current Plan Year to fund coverage that will be provided during a subsequent Plan Year;
 - (3) The Participant may be given the option to pay all or a portion of his/her share of the premium upon the termination of his/her leave; or
 - (4) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.
- (C) **Return from FMLA Leave.** If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Flexible Benefits Plan upon his/her return from such leave on the same basis that the Participant was participating in the Flexible Benefits Plan prior to his/her leave, or as otherwise required by FMLA.
- (D) **Exception to General Rule.** If the Participant's Employer's participation in the Administrative Agreement is terminated as set forth in Section 3.02(A)(3), this Section 3.04 will not apply and the Participant's participation in any Welfare Benefits shall terminate on the date that his/her Employer's participation in the Administrative Agreement is terminated.

Section 3.05 Other Approved Paid Leaves. This Section 3.05 applies only to those Participants who take a paid leave of absence approved by the Employer, other than FMLA leave or leave under USERRA.

- (A) **General Rule.** Except as otherwise provided in Section 3.05(C), if a Participant goes on a qualifying paid leave approved by the Employer, the Employer will continue to maintain the Participant's benefits under the Optional Basic Life / Accidental Death & Dismemberment Insurance Plan, the Group Universal Life Insurance Plan, the Child Term Life Insurance Plan, and the DCAP on the same terms and conditions as though the Participant were still an active Employee.
- (B) **Payment of Participant's Share of the Premium.** The Participant's share of the premium will be deducted from the Participant's Compensation during the leave.
- (C) **Exception to General Rule.** If the Participant's Employer's participation in the Administrative Agreement is terminated as set forth in Section 3.02(A)(3), this Section 3.05 will not apply and the Participant's participation in any Welfare Benefits shall terminate on the date that his/her Employer's participation in the Administrative Agreement is terminated.

Section 3.06 Other Approved Unpaid Leaves. This Section 3.06 applies only to those Participants who take an unpaid leave of absence approved by the Employer, other than FMLA leave or leave under USERRA.

- (A) **General Rule.** Except as otherwise provided in Section 3.06(D), if a Participant goes on a qualifying unpaid leave of absence approved by the Employer, the Participant may cease to participate in any Welfare Benefits. If the Participant opts to continue his/her coverage, the Employer will continue to maintain the Participant's benefits under the Pre-Tax Benefits and the After-Tax Benefits on the same terms and conditions as though the Participant were still an active Employee.
- (B) **Options for Payment of Participant's Share of the Premium.** If the Participant opts to continue his/her coverage, the Participant must pay his/her share of the premium on an after-tax basis in accordance with the Employer's established policies and procedures.
- (C) **Return from Leave.** If the Participant's coverage ceases while the Participant is on unpaid leave, the Participant will be permitted to reenter the Flexible Benefits Plan upon his/her return from such leave on the same basis on which the Participant was participating in the Flexible Benefits Plan prior to his/her leave.

- (D) **Exception to General Rule.** If the Participant's Employer's participation in the Administrative Agreement is terminated as set forth in Section 3.02(A)(3), this Section 3.06 will not apply and the Participant's participation in any Welfare Benefits shall terminate on the date that his/her Employer's participation in the Administrative Agreement is terminated.

ARTICLE IV OPTIONAL BENEFITS

Section 4.01 Pre-Tax Benefit Choices. Each Participant may elect to reduce his/her Compensation and have the amount of Compensation so reduced applied by the Employer toward the cost of benefits available under one or more of the Pre-Tax Component Plans and/or Pre-Tax Benefits under this Flexible Benefits Plan. For Insured Benefits, the monthly premiums for insurance coverage are determined by the applicable Insurance Company and may change from time to time. If a Participant covers a Domestic Partner under one or more of the Pre-Tax Component Plans and/or Pre-Tax Benefits, the portion of the cost of the benefit attributable to coverage for the Domestic Partner shall be reduced from the Participant's Compensation on an after-tax basis.

The Pre-Tax Component Plans are maintained under separate plan documents. The exact terms and conditions of the Pre-Tax Component Plans are set forth in each of those Plans. By this reference, the Employer incorporates those plans within this Flexible Benefits Plan.

The terms and conditions of the Pre-Tax Benefits are as follows:

- (A) **Health Flexible Spending Account ("Health FSA").** Participants may elect to make contributions to a Health FSA under the General Purpose option or, provided that the Participant is participating in a "high-deductible health plan" option under the Farm Credit Foundations Medical Plan, under the Limited Purpose option. Both these options are described in Article A-1 of Appendix A. A Health FSA enables Participants to elect pre-tax salary reductions and receive reimbursements for their unreimbursed Qualified Medical Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Code § 105(h) so that the Employer's reimbursements from the Health FSA are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are provided in Appendix A.
- (B) **Dependent Care Assistance Plan ("DCAP").** Participants may elect to make contributions to a DCAP. A DCAP enables Participants to elect pre-tax salary reduction and receive reimbursements for their Qualified Dependent Care Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Code § 129 so that the Employer's reimbursements from the DCAP are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are provided in Appendix B.
- (C) **Vision Plan.** Participants may elect to receive insurance for vision coverage through the Vision Plan. The terms and conditions of this Pre-Tax Benefit are provided in Appendix C.
- (D) **Voluntary AD&D Insurance Plan.** Participants may elect to receive insurance for accident, death, and dismemberment coverage through the Voluntary AD&D Insurance Plan. The terms and conditions of this Pre-Tax Benefit are provided in Appendix E.

- (E) **Optional Basic Life / Accidental Death & Dismemberment Insurance Plan.** Participants may elect to receive life insurance through the Optional Basic Life / Accidental Death & Dismemberment Insurance Plan. The Optional Basic Life / Accidental Death & Dismemberment Insurance Plan is only a Pre-Tax Benefit to the extent the group term life insurance coverage provided thereunder does not exceed \$50,000 when such coverage is combined with the group term life insurance coverage under the Basic Life Plan. The terms and conditions of this Pre-Tax Benefit are provided in Appendix F.
- (F) **Health Savings Account.** Participants may elect to make contributions on a pre-tax basis to a Health Savings Account (“HSA”). The HSA is not an employer-sponsored benefit plan. It is an individual trust or custodial account that Participants open with an HSA trustee/custodian and which may be used to reimburse Participants for “eligible medical expenses” as set forth in Code § 223. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix H.

The election of a Pre-Tax Benefit or Pre-Tax Component Plan is subject to the terms and conditions of Article V.

Section 4.02 Taxable Benefit Choices. Each Participant may elect to reduce his/her Compensation on an after-tax basis and have the amount of Compensation so reduced applied by the Employer toward the cost of benefits available under one or more of the After-Tax Benefits. The After-Tax Benefits are Insured Benefits. The monthly premiums for insurance coverage are determined by the applicable Insurance Company and may change from time to time.

The terms and conditions of the After-Tax Benefits are as follows:

- (A) **Group Universal Life Insurance Plan.** Participants may elect to receive universal life insurance through the Group Universal Life Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix G.
- (B) **Child Term Life Insurance Plan.** Participants may elect to receive life insurance for their dependent(s) through the Child Term Life Insurance Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix I.
- (C) **Optional Basic Life / Accidental Death & Dismemberment Insurance Plan.** Participants may elect to receive optional basic life and accidental death and dismemberment insurance through the Optional Basic Life / Accidental Death & Dismemberment Insurance Plan. The Optional Basic Life / Accidental Death & Dismemberment Insurance Plan is only an After-Tax Benefit to the extent the group term life insurance coverage provided thereunder exceeds \$50,000 when such coverage is combined with the group term life insurance coverage under the Basic Life Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix F.

A Participant covering a Domestic Partner pursuant to the terms and conditions of one or more Welfare Benefits (e.g., a Pre-Tax Benefit) must reduce the portion of his/her Compensation attributable to the cost of coverage for the Domestic Partner on an *after-tax* basis.

ARTICLE V ELECTION OF BENEFITS

Section 5.01 Election of Benefits. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits that are available under this Flexible Benefits Plan. As part of the Participant's election, the Participant must execute an agreement to reduce Compensation. The Plan Administrator may require such agreement 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 Employee who wishes to receive benefits under this Flexible Benefits Plan must:

- (A) Affirmatively request to participate in this Flexible Benefits Plan;
- (B) Designate his/her desired coverage of a Pre-Tax Benefit and/or After-Tax Benefit under this Flexible Benefits Plan and/or coverage under a Pre-Tax Component Plan;
- (C) Elect that the cost of any Pre-Tax Benefit, and/or Benefit Package Option under a Pre-Tax Component Plan, for which the Employee has enrolled, be paid through a reduction in the amount of the Employee's Compensation as provided in this Flexible Benefits Plan; and
- (D) Elect that the cost of any After-Tax Benefit, for which the Employee has enrolled, be paid through a reduction in the Employee's Compensation on an after-tax basis, as provided in this Flexible Benefits Plan.

Section 5.02 Election Procedure. During the Annual Enrollment Period of each Plan Year, the Plan Administrator must provide each Participant the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.

Section 5.03 New Participants. An Employee who becomes, or is about to become, eligible to participate in this Flexible Benefits Plan during a Plan Year and who desires to make elections for the remainder of the Plan Year must do so in the manner prescribed by the Plan Administrator. Any such elections must be made within the time period prescribed by the Plan Administrator, but in no event later than 31 days after the date the Employee becomes eligible to participate in this Flexible Benefits Plan. The elections made by the Employee shall be effective on the later of (i) the first day of the pay period for which the Employee is eligible to participate in this Flexible Benefits Plan or (ii) the first day of the pay period next following the date on which the Employee's desired elections are received by the Plan Administrator.

Section 5.04 Absence of Election. The Employee's failure to provide his/her desired elections to the Plan Administrator by the required date shall be treated as an election not to reduce his/her Compensation for the Plan Year. If the Participant is currently participating in the Flexible Benefits Plan pursuant to elections previously provided to the Plan Administrator, and such Participant fails to provide his/her desired elections for the following Plan Year during the Annual Enrollment Period (or, if later, prior to the December 31 immediately following the Annual Enrollment Period), such failure to provide new elections shall be treated as an election to participate on the same basis in the subsequent Plan Year as in the current Plan Year.

This rule, however, is subject to the following exceptions:

- (A) **Change in Cost/Benefits.** The Plan Administrator may modify any prior elections to reflect any changes in the benefits that are available under the Flexible Benefits Plan or in the cost of the benefits elected by the Participant;
- (B) **Spending Account Plans and Health Savings Account.** If the Participant has elected to participate in the Health FSA and/or the DCAP and/or the Health Savings Account during the current Plan Year, but has failed to complete a new election for a subsequent Plan Year, the Participant's election with respect to such Plans will be reduced to zero dollars for any subsequent Plan Years; and
- (C) **Required Re-enrollment.** If the Plan Administrator requires that certain benefits be affirmatively elected for the subsequent Plan Year and the Participant does not elect to participate in such benefit(s), the Participant will be deemed to have waived coverage for that benefit.

Section 5.05 Election is Irrevocable. After a Plan Year has commenced, the Participant shall not be allowed to revoke or amend his/her elections for the affected Plan Year except as provided in Sections 5.06 through 5.14.

Section 5.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below, and the requirements of this Section 5.06 are satisfied.

- (A) **Change in Status.** The following events constitute a Change in Status:
 - (1) **Change in Marital Status.** A change in the Participant's legal marital status, including the following: marriage, divorce, the death of a Dependent-Spouse, legal separation, and annulment.
 - (2) **Change in Number of Dependents.** A change in the number of the Participant's Dependents (other than a Domestic Partner), including the following: birth, death, adoption, and placement for adoption.

- (3) Change in Employment Status. Any of the following events that change the employment status of the Participant or the Participant's Dependent(s) (other than a Domestic Partner):
- (a) A termination or commencement of employment;
 - (b) A commencement of, or return from, an unpaid leave of absence;
 - (c) A change in worksite, if such a change affects eligibility under this Flexible Benefits Plan, including eligibility for the Pre-Tax Benefits or After-Tax Benefits, or eligibility under a Pre-Tax Component Plan;
 - (d) A change in the employment status of the Participant or the Participant's Dependent(s) (other than a Domestic Partner), (e.g., a change from salaried to hourly employment), if the change affects the eligibility of the Participant or the Participant's Dependent(s) under (i) this Flexible Benefits Plan, including for the Pre-Tax Benefits or After-Tax Benefits, (ii) a Pre-Tax Component Plan, or (iii) a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant or the Participant's Dependent(s); or
 - (e) A strike or lockout.
- (4) Change in Dependent Eligibility. An event that causes a Participant's Dependent(s) (other than a Domestic Partner) to satisfy or cease to satisfy the eligibility conditions for coverage under the Pre-Tax Benefits or After-Tax Benefits of this Flexible Benefits Plan or a Pre-Tax Component Plan on account of the Dependent's attainment of a certain age, student status, or any similar circumstances.
- (5) Change in Residence. A change in the place of residence of the Participant, the Participant's spouse, or the Participant's Dependent(s) (other than a Domestic Partner), if such a change affects eligibility under this Flexible Benefits Plan, including the Pre-Tax Benefits or After-Tax Benefits, or a Pre-Tax Component Plan.
- (B) **Consistency.** An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service Regulations.

- (C) **Status Change Form.** Each Participant must complete a status change form and return such form, in such medium as prescribed by the Plan Administrator (e.g., paper, electronic, or otherwise), to the Plan Administrator no later than 31 days after the date of the Change in Status, if such Participant desires to change any existing benefit elections on account of such change.
- (D) **Approval of Change.** The Plan Administrator must approve any election change resulting from a Change in Status. The Plan Administrator may request and receive any documents the Plan Administrator deems necessary to substantiate a Change in Status. Such documents shall include, but not be limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from spouse's former employer, or any other relevant documents. All such documents shall be provided at the Participant's expense, if any.

Section 5.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

- (A) **HIPAA Special Enrollment Rights.** After a Plan year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's Spouse, or a Dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either Subsections (1), (2), (3) or (4) below:
 - (1) Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP. A Participant or his/her Spouse or Dependent becomes eligible on or after April 1, 2009, for a state premium assistance subsidy under a group health plan of the Employer from Medicaid or a state's children's health insurance program (SCHIP);
 - (2) Loss of Eligibility for Medicaid or SCHIP Coverage. The Medicaid or SCHIP coverage of a Participant or his/her Spouse or Dependent is terminated on or after April 1, 2009, as a result of a loss of eligibility.
 - (3) Loss of Other Coverage. Medical coverage was declined under a group health plan sponsored by the Employer because of other medical coverage, and eligibility for such other coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:
 - (a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;

- (b) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits; and
- (c) 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.

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).

- (4) Acquisition of a New Dependent. The Participant acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption.

(B) **New Election Corresponds with and is Consistent with HIPAA Special Enrollment Rights.** A change in elections pursuant to this Section 5.07 must correspond with and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).

- (1) Increase in Salary Reductions. A Participant may elect to increase the amount by which his/her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant and/or a Dependent of the Participant in the group health plan.

- (2) Election to Add Previously Eligible Dependents. An election to add previously eligible Dependents (other than a Domestic Partner) as a result of a loss of other coverage or the acquisition of a Dependent shall be considered to be consistent with the special enrollment rights.

(C) **Status Change Form.** Each Participant must complete a status change form and submit such form, in such medium as prescribed by the Plan Administrator (e.g., paper, electronic, or otherwise), to the Plan Administrator no later than 60 days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (A)(1) or (A)(2) above, and no later than 31 days after the date of the event giving rise to the right to exercise the special enrollment rights under (A)(3) or (A)(4) above.

(D) **Approval of Change.** The Plan Administrator must approve any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f).

Section 5.08 Election Change Due to Change in Coverage.

(A) Cessation or Significant Curtailment in Coverage.

- (1) Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed (but not lost) during the Plan Year, the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. Coverage under a plan is deemed “significantly curtailed” only if there is an overall reduction in coverage provided to Participants under the plan so as to constitute reduced coverage to Participants in general.
- (2) Significant Curtailment With Loss of Coverage.** If the Plan Administrator determines that coverage under a Benefit Package Option Plan is significantly curtailed during the Plan Year and that the curtailment constitutes a loss of coverage with respect to a Participant (or the Participant’s Dependent (other than a Domestic Partner)), the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. If no similar Benefit Package Option is available, the Participant may elect to drop coverage. For purposes of this Section 5.08(A)(2), a loss of coverage means a complete loss of coverage under the Benefit Package Option (including the elimination of a Benefits Package Option or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion and in accordance with prevailing Internal Revenue Service guidance, may determine that the following constitute a loss of coverage:

 - (a)** A substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network);
 - (b)** A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant’s Dependent (other than a Domestic Partner) is currently in a course of treatment; or
 - (c)** Any other similar fundamental loss of coverage.

- (3) **Determinations to be Made by the Plan Administrator.** The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance and based upon the surrounding facts and circumstances, whether a curtailment is “significant,” whether a curtailment represents a loss of coverage with respect to a particular individual, and whether a substitute Benefit Package Option provides “similar coverage.”
- (B) **Addition or Improvement of a Benefit Package Option.** If, during the Plan Year, a new Benefit Package Option is added, or if coverage under an existing Benefit Package Option is significantly improved during the period of coverage, a Participant may elect to add the new Benefit Package Option or the improved Benefit Package Option, and to make corresponding changes with respect to other Benefit Package Options providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole discretion, shall decide, based upon the surrounding facts and circumstances and in accordance with prevailing Internal Revenue Service guidance, whether a new Benefit Package Option has been added, whether an existing Benefit Package Option has been significantly improved, and/or whether another Benefit Package Option constitutes “similar coverage.”
- (C) **Change in Coverage of Spouse or Dependent under Plan of Another Employer (“Election Lock”).** After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis if the change is on account of and corresponds with a change made under the plan of the employer of the Participant’s Dependents (other than a Domestic Partner, but including a former Dependent-Spouse, or the Participant’s dependent. Any such change is permitted only if (i) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final Internal Revenue Service regulations under Code § 125; or (ii) the period of coverage under the plan of such other employer is different than the Plan Year for this Flexible Benefits Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant’s spouse, former spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.

- (D) **Loss of Coverage Under Other Group Health Coverage.** After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis to add coverage for the Participant or the Participant's spouse or dependent(s) if the Participant or the Participant's spouse or dependent(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. For purposes of this provision, this includes the following: (i) A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

Section 5.09 Election Change Due to FMLA Leave. A Participant who is taking leave under FMLA may revoke an existing election of accident or health plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.04 of this Flexible Benefits Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 5.06(A)(3), provided the requirements of that Section are satisfied.

Section 5.10 Election Change Due to Issuance of Judgment, Decree, or Order. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant's Dependent child, including a foster child who is a Dependent of the Participant, a Participant may:

- (A) Change his/her election to provide coverage for the Dependent child, provided that the Order requires the Participant to provide such coverage; or
- (B) Change his/her election to revoke coverage for the Dependent child, if the Order requires that another individual, including the Participant's Dependent-spouse or former Dependent-spouse, provide coverage under that individual's plan and such coverage is, in fact, provided.

Section 5.11 Election Change Due to Medicare/Medicaid Entitlement. If a Participant or a Participant's Dependent(s) (other than a Domestic Partner) who is entitled to receive benefits under a Pre-Tax Component Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Pre-Tax Component Plan. Additionally, if a Participant, a Participant's spouse, or a Participant's Dependent(s) (other than a Domestic Partner) who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Pre-Tax Component Plan. Any change made under this Section 5.11 shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Pre-Tax Component Plan is governed by, and subject to, the terms of each such respective plan.

Section 5.12 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year, if the Plan Administrator determines such action is necessary or advisable to:

- (A) Satisfy any Code nondiscrimination requirements applicable to this Flexible Benefits Plan or any Pre-Tax Component Plan;
- (B) Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Pre-Tax Benefits or Pre-Tax Component Plan than would otherwise be recognized; or
- (C) Maintain the qualified status of benefits received under this Flexible Benefits Plan.

In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 5.13 Election Change Due to Significant Change in Cost.

- (A) **Increase in Participant's Share of the Cost.** If the Participant's share of the premium for coverage under a Benefit Package Option (other than the Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount, on a prospective basis, or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) that provides similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option and drop coverage altogether.
- (B) **Decrease in Participant's Share of the Cost.** If the Participant's share of the premium for coverage under a Benefit Package Option (other than the Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.
- (C) **Other Provisions.** The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a change in cost is "significant" and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.

- (D) **Special Provisions Applicable to the DCAP.** This Section 5.13 does not apply to the DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in Internal Revenue Service Regulations) to the Participant.

Section 5.14 Automatic Election Change for Insignificant Changes in Cost. If the Participant's share of the premium for health and/or accident coverage increases or decreases during the Plan Year by an insignificant amount, the Participant's election shall be increased or decreased, on a prospective basis, by the amount of such increase or decrease. The Plan Administrator, on a reasonable and consistent basis, shall automatically effectuate this prospective increase or decrease in the elective contributions of the affected Participants in accordance with such cost changes. The Plan Administrator, in its sole discretion, shall decide whether increases or decreases in cost are "insignificant" based upon all the surrounding facts and circumstances, including but not limited to, the dollar amount and/or the percentage amount of the change.

Section 5.15 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections, pursuant to this Article V, must complete and submit a status change form and/or such other forms as the Plan Administrator may require. The Plan Administrator may require such form(s) 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. If an election is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within 31 days after the date giving rise to the request for an election change, except as provided in Section 5.07(A)(1) and (2) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within 60 days after the date giving rise to the request for an election change.

Section 5.16 Effective Date of Election Changes. Except as specifically provided to the contrary in this Section 5.16, all election changes will take effect on the date of the election change event provided that the Participant has timely completed and submitted the appropriate status change forms in accordance with Section 5.06(C). Subject, however, to the provisions of the underlying Pre-Tax Component Plan, an election to increase the amount by which a Participant's Compensation is reduced in order to fund the increased cost of providing benefits under a Pre-Tax Component Plan to a newly adopted Dependent or newborn (and any other individual being added to coverage pursuant to Section 5.07(A)(4)) may be given retroactive effect to the date of birth or the date of adoption.

If the Participant does not timely complete and submit the appropriate change forms, the Participant shall not be able to change the dollar amount of his/her election even though coverage for the Participant and/or his/her Dependent(s) may be lost pursuant to the terms of the underlying Welfare Benefits plan.

Section 5.17 Elections of Former Participants Rehired Within One Month of Termination. If a former Participant is rehired within one month after the date on which the Participant's employment relationship with the Employer was terminated, the Participant will be reinstated with the same elections the Participant had before termination unless:

- (A) The Participant would be permitted to make an election change under this Article V for a reason other than a change in his/her employment with the Employer;
- (B) The Plan Year ended on or after the date on which the employment relationship was terminated but before the date of reinstatement; or
- (C) The underlying Welfare Benefits plan does not permit the reinstatement.

Section 5.18 Special Election Change Rule for Pre-Tax Component Plans. If a Participant in a Pre-Tax Component Plan experiences an event that would permit him/her to change his/her election in accordance with this Article V, such an election may be permitted as described above, except that a Participant may not change from one Benefit Package Option to another unless HIPAA special enrollment rights apply.

Section 5.19 Maximum Benefits. The maximum benefits under this Flexible Benefits Plan are the maximum benefits specified under this Flexible Benefits Plan or the Pre-Tax Component Plans, as applicable. Moreover, no Participant shall be entitled to reduce Compensation by more than the aggregate maximum amount of reimbursements available under this Flexible Benefits Plan and/or the Pre-Tax Component Plans elected by the Participant.

**ARTICLE VI
CLAIMS ADMINISTRATION**

Section 6.01 Claims Administrators.

- (A) **Fully Insured Benefits.** The Claims Administrator for each Insured Benefit is the Insurance Company that is providing the underlying policy of insurance with respect to such Insured Benefit.
- (B) **Farm Credit Foundations Medical and Dental Plans.** The Claims Administrator for the Farm Credit Foundations Medical Plan and the Farm Credit Foundations Dental Plan shall be the person or entity that is designated under the terms and conditions of each respective plan.
- (C) **Spending Accounts.** The Claims Administrator for the Health FSA and DCAP benefits is set forth on the Schedule of Service Providers, which is attached to this Flexible Benefits Plan.

Section 6.02 Duties of the Claims Administrator. The Claims Administrator shall have the discretionary power and authority to perform the following duties:

- (A) Make determinations as to the eligibility of individuals to participate in the applicable Welfare Benefit and/or to be considered as a dependent;
- (B) Make determinations relating to coverage under the applicable Welfare Benefit, including termination and continuation of a Participant's coverage;
- (C) Receive claims for benefits and render decisions with respect to such claims under the applicable Welfare Benefit;
- (D) Compute the amounts payable for any Participant or other person in accordance with the provisions of this Flexible Benefits Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid;
- (E) Whenever it may be necessary, investigate and determine the eligibility for coverage of an applicant where the existence of any fact, status, or circumstance is a condition of coverage;
- (F) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of claims under the applicable Welfare Benefit;
- (G) Adopt such rules and procedures relating to the administration of claims as it deems necessary or desirable;

- (H) Be responsible for all claims administration reporting and disclosure requirements for the applicable Welfare Benefit under the law;
- (I) Receive from the Employer, Employees, Participants and other persons, such information as shall be necessary for the proper administration of claims under the applicable Welfare Benefit;
- (J) Furnish to the Employer upon request, reports with respect to the administration of claims under the applicable Welfare Benefit;
- (K) Maintain all claims administration records of the applicable Welfare Benefit; and
- (L) Provide for and administer a mechanism for the appeal of denied claims in accordance with the provisions of the applicable Welfare Benefit.

Section 6.03 Claims Procedure.

(A) Fully Insured Benefits.

- (1) Benefit Claims. If and to the extent the claims procedures provided by an Insurance Company for claims for an Insured Benefit are different from the claims procedures of this Article VI, the claims procedures of the Insurance Company will control.
- (2) Benefit Determinations. The Claims Administrator for each fully insured benefit, whether paid for on an after-tax or pre-tax basis, is hereby delegated full discretionary authority to make all determinations as to the right of any person to such Pre-Tax Benefit or After-Tax Benefit under this Flexible Benefits Plan. All decisions of such Claims Administrators shall be final and binding.

(B) Farm Credit Foundations Medical and Dental Plans.

- (1) Benefit Claims. The claims procedures for benefits under the Farm Credit Foundations Medical Plan and the Farm Credit Foundations Dental Plan are provided under each respective Plan.
- (2) Benefit Determinations. Whether or not the Claims Administrator of the Farm Credit Foundations Medical Plan and the Farm Credit Foundations Dental Plan has been delegated full discretionary authority with respect to benefit determinations is set forth in each respective Plan.

(C) **Spending Accounts.**

- (1) Benefit Claims. The provisions of this Article VI shall apply to claims for benefits under the Health FSA and DCAP to the extent that they are not inconsistent with the claims procedures set forth in Appendix A and Appendix B, respectively. Prior to making any payment of Health FSA or DCAP benefits under this Flexible Benefits Plan, the Plan Administrator and/or Claims Administrator may require the Participant to provide such information and/or to complete such documents or forms that may be necessary for the proper administration of this Flexible Benefits Plan. The Plan Administrator and the Claims Administrator may rely upon all such furnished information, including the Participant's current mailing address.
- (2) Benefit Determinations. The Plan Administrator has full discretionary authority with respect to the Health FSA and DCAP benefits.

Section 6.04 Health FSA and DCAP - Claims Denial. If a claim for benefits is denied in whole or in part, the Claims Administrator shall, within a reasonable period of time, but no later than ninety (90) 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:

- (A) Shall be in writing;
- (B) Shall be written in a manner meant to be understood by the claimant; and
- (C) Shall contain the following:
 - (1) The specific reason(s) for denial of the claim;
 - (2) A specific reference to the pertinent Flexible Benefits Plan provisions upon which the denial is based;
 - (3) A description of any additional material or information necessary for the Claimant to perfect the claim, along with an explanation as to why such material or information is necessary; and
 - (4) An explanation of this Plan's claim review procedure.

Section 6.05 Health FSA and DCAP - Appeal of Claim Denial to Claims Administrator. Upon the denial of a claim in whole or in part, the claimant or the claimant's duly authorized representative shall have sixty (60) days within which to file with the Claims Administrator a written request for a review of such denial.

The claimant or the claimant's 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 and comments in writing.

The Claims Administrator shall as promptly as is practicable, ordinarily within sixty (60) days, except in special circumstances, but in no case later than 120 days after receipt of the written request, review and determine the proper amount due for said claim. 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. Such notice of denial shall be in writing, shall be written in a manner meant to be understood by the claimant, and shall contain the specific reason(s) for denial of the claim and a specific reference to the pertinent Flexible Benefits Plan provisions upon which the denial is based.

Section 6.06 Health FSA and DCAP – Coordination of Benefits. No expenses shall be reimbursed under this Flexible Benefits Plan which have already been reimbursed under any other plan that covers the Participant, whether such coverage is as an Employee, Spouse or Dependent.

Section 6.07 Health FSA and DCAP – Electronic Payment Card Reimbursements. If the funds in a Health FSA or DCAP are accessible by electronic debit card, a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance.

Section 6.08 Litigation of Claim. Prior to initiating legal action concerning a claim for an Insured Benefit or a claim under the Health FSA or DCAP in any court, state or federal, against the Flexible Benefits Plan, the Employer, and/or the Plan Administrator, a claimant must first exhaust the administrative remedies provided in the claims procedures of the underlying Insured Benefit, the Health FSA, and/or the DCAP, as applicable, or, if not provided therein, as provided in this Article VI. Failure to exhaust such administrative remedies shall be a bar to any civil action concerning a claim for benefits under the Flexible Benefits Plan. If the Claims Administrator, acting pursuant to the underlying Insured Benefit's written claims procedure or the Health FSA's or DCAP's written claims procedures, as applicable, 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 hundred eighty (180) days following the date of the Claims Administrator's final determination.

**ARTICLE VII
PLAN ADMINISTRATION**

Section 7.01 Plan Administrator. The Plan Administrator is the Farm Credit Foundations Trust Committee. The Plan Administrator is responsible for the administration of the Flexible Benefits Plan. The Plan Administrator has the full discretionary authority to administer the Flexible Benefits Plan, subject to the requirements of law. Except as otherwise provided by law or otherwise delegated in this Flexible Benefits 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 Flexible Benefits Plan;
- (B) Require each Participant to supply such information and sign such documents as may be necessary to administer this Flexible Benefits Plan;
- (C) Interpret, construe and carry out the provisions of the Flexible Benefits Plan and render decisions on the administration of the Flexible Benefits Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of this Flexible Benefits Plan; and
- (D) Appoint such agents, attorneys, accountants and consultants and any other person required for proper administration of the Flexible Benefits Plan.

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

Section 7.02 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Flexible Benefits Plan in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.

**ARTICLE VIII
TERMINATION AND AMENDMENT OF THE PLAN**

Section 8.01 Termination and Amendment. The Employer may amend or terminate this Flexible Benefits Plan, including without limitation the addition or deletion of one or more Welfare Benefits, at any time in accordance with the procedures established by the Farm Credit Foundations Plan Sponsor Committee, which procedures are hereby incorporated by reference. Any approved change to the Flexible Benefits Plan shall be made through a written instrument. Upon termination of this Flexible Benefits Plan, the Employer shall give notice of the termination to all Participants, all individuals then receiving benefits under this Flexible Benefits Plan and any other affected person. Upon termination of the Flexible Benefits Plan, the Employer will refund to each Participant only his/her credit amount, if any, in the Health FSA or the DCAP.

ARTICLE IX MISCELLANEOUS

Section 9.01 Construction. Words used in the masculine also apply to the feminine where applicable, and wherever the context of the Flexible Benefits Plan dictates, the plural includes the singular and the singular includes the plural.

Section 9.02 Employment Not Guaranteed. Nothing contained in this Flexible Benefits Plan or in any other plan which is a part of this Flexible Benefits Plan, or any modification or amendment to the Flexible Benefits 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, or Employee of the Employer, or its agents, or against the Plan Administrator, except as expressly provided by the Flexible Benefits Plan.

Section 9.03 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 Flexible Benefits 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 his duties, responsibilities and obligations under the Flexible Benefits Plan or under his/her job duties related to this Flexible Benefits 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 9.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents necessary to implement this Flexible Benefits Plan.

Section 9.05 Legal Service. Process can be served on the Flexible Benefits Plan by directing such legal service to the Claims Administrator and/or the Plan Administrator.

Section 9.06 Limitation of Rights. Neither the establishment of this Flexible Benefits Plan, nor any amendment, nor the payment of any benefits 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 9.07 Limitation on Liability. A 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 his/her duties under this Flexible Benefits Plan unless he/she acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 9.08 Named Fiduciary. The named fiduciary of this Flexible Benefits Plan shall be the Farm Credit Foundations Trust Committee (“Trust Committee”). The Plan Fiduciary Committee shall have complete authority to control and manage the operation and administration of this Flexible Benefits 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 Flexible Benefits Plan to the extent designated in such contract. In addition, the Insurance Company providing and making benefit payments for a particular Insured Benefit shall be the named fiduciary of this Flexible Benefits Plan with respect to that benefit.

Section 9.09 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 for a Pre-Tax Benefit under this Flexible Benefits 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 Flexible Benefits 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 9.10 Nonalienation of Benefits. Benefits payable under this Flexible Benefits 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 the Flexible Benefits Plan or underlying policy of insurance and/or (b) as expressly permitted under the terms of the Flexible Benefits Plan or underlying policy of insurance; and any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Flexible Benefits 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 Flexible Benefits Plan.

Section 9.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Flexible Benefits 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 Flexible Benefits Plan on a prospective basis only.

Section 9.12 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 Flexible Benefits Plan, and then only to the extent of the benefits payable under the Flexible Benefits Plan to such Participant or beneficiary. The Employer will make all payments of benefits this Flexible Benefits Plan provides solely from the assets of the Employer, and the Plan Administrator is not liable for payment of benefits in any manner.

Section 9.13 Source of Funds. The Pre-Tax Component Plans shall be funded by direct payments from the 501(c)(9) trust. All other Welfare Benefits under this Flexible Benefits Plan may, at the Employer’s discretion, be funded by direct payments from the 501(c)(9) trust. The trust shall be funded by the Employer and voluntary Employee Compensation reductions subject to all of the provisions of this Flexible Benefits Plan.

Section 9.14 **State Law.** The laws of the state of Delaware will determine all questions arising with respect to the provisions of this Flexible Benefits Plan except to the extent superseded by Federal law.

FARM CREDIT FOUNDATIONS
SCHEDULE OF SERVICE PROVIDERS

The service providers for each of the following plans under this Flexible Benefits Plan are as follows:

- (1) **Health FSA (Appendix A):** The Claims Administrator for the Health FSA is Bank of America, Inc.
- (2) **DCAP (Appendix B):** The Claims Administrator for the DCAP is Bank of America, Inc.
- (3) **Health Savings Account (Appendix H):** The custodian/trustee of the Health Savings Account is Bank of America, Inc.

FARM CREDIT FOUNDATIONS

HSA MAXIMUM CONTRIBUTION LIMIT SCHEDULE

The Maximum Annual Contribution Limit limits the total amount that may be contributed to an HSA in a calendar year by an individual and/or on behalf of an individual. The Maximum Annual Contribution Limit is equal to the annual maximum dollar limit established by Congress. The dollar limit established by Congress is adjusted annually by the Internal Revenue Service ("IRS") to reflect changes in the cost of living.

For 2010, the Maximum Annual Contribution Limit, as adjusted by the IRS, is as follows:

- (1) Single Coverage: **\$3,050**
- (2) Family Coverage: **\$6,150**

In addition, individuals who are or will be age 55 or older on the last day of the Plan Year may make additional catch-up contributions (i.e., in excess of the Maximum Annual Contribution Limit), not to exceed \$1,000 for the Plan Year. The Maximum Annual Contribution Limit, as shown above, does not include any catch-up contributions.

In the event there is a change in the Maximum Annual Contribution Limit, this Schedule may be updated by the Plan Administrator, as provided in Sections H1.09 and H1.11 of the Flexible Benefits Plan.