

**FARM CREDIT FOUNDATIONS
RETIREE MEDICAL PLAN**

WRAP AROUND PLAN DOCUMENT

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**FARM CREDIT FOUNDATIONS
RETIREE MEDICAL PLAN**

PREAMBLE

The Farm Credit Foundations Retiree Medical Plan (“Retiree Medical 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 that are parties to the Farm Credit System Administrative Agreement Regarding Employee Benefit Plans (“Administrative Agreement”).

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

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

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

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

ARTICLE I INTRODUCTION

Section 1.01 Purpose of Retiree Medical Plan. The purpose of the Retiree Medical Plan is to provide Eligible Retirees and their Eligible Dependents with medical benefits.

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

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

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

Section 1.05 Effect on Prior Plans. Prior to January 1, 2007, AgriBank and its affiliated associations, U.S. AgBank and its affiliated associations, Northwest Farm Credit Services, and other employers within the federal Farm Credit System that 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 that were previously sponsored separately. This Retiree Medical Plan amends and restates the separate retiree medical benefit plans that were previously sponsored by these Farm Credit System employers. As part of this amendment and restatement, the name of the Retiree Medical Plan is changed to the Farm Credit Foundations Retiree Medical Plan.

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

Section 1.07 Funding Policy and Method. The medical benefits under this Retiree Medical Plan are funded by the Employer. The cost of providing these medical benefits may be paid for by Employer and Retiree contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under this Retiree Medical Plan, but shall have no obligation to do so.

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

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

ARTICLE II DEFINITIONS

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

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

Section 2.02 “Age 65 and Older Coverage” means the coverage provided through Article VII of this Retiree Medical Plan.

Section 2.03 “Benefit Description” means the Benefit Description for the Farm Credit Foundations Retiree Medical Plan, which is attached to this Wrap Around Plan Document and is incorporated by reference.

Section 2.04 “Benefit Schedules” means the various Benefit Schedules for the Farm Credit Foundations Retiree Medical Plan, which are incorporated by reference and made a part of the Benefit Description. Any definitions in the Benefit Schedules are incorporated by reference as part of this Retiree Medical Plan.

Section 2.05 “Calendar Year” means the period of twelve (12) consecutive months from January 1 through December 31.

Section 2.06 “Child” or “Children” when either of such terms is used in the definition of Dependent, includes the Covered Retiree’s (or covered Domestic Partner’s) natural children, adopted children, stepchildren, foster children, or children under the Covered Retiree’s (or covered Domestic Partner’s) legal guardianship by court order.

Section 2.07 “Claimant” means a Covered Person who files a Claim for benefits pursuant to this Retiree Medical Plan.

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

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

Section 2.10 “Covered Dependent” means an Eligible Dependent who is enrolled in this Retiree Medical Plan pursuant to Article IV.

Section 2.11 “Covered Person” means a Covered Retiree or Covered Dependent.

Section 2.12 “**Covered Retiree**” means an Eligible Retiree who is enrolled in this Retiree Medical Plan pursuant to Article IV.

Section 2.13 “**Dependent**” has the meaning set forth in the Insurance Contract for individuals who are age 65 or older and has the following meaning for individuals who are under age 65:

- (A) A Retiree’s Spouse, but only if the Spouse is not divorced or legally separated from the Retiree;
- (B) An Employee’s or Disabled Person’s Domestic Partner;
- (C) A Retiree’s Children if such Children:
 - (1) Are under age 19; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Retiree for financial support; and
 - (4) Are either (a) living with the Retiree in a normal parent-child relationship, or (b) entitled to the provision of medical coverage under this Retiree Medical Plan by virtue of a court order under which the Retiree is legally responsible to provide medical coverage;
- (D) A Retiree’s Children if such Children:
 - (1) Are between the ages of 19 and 25; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Retiree for financial support; and
 - (4) Are either (a) enrolled in and attending an accredited educational or vocational institution with full-time student status; or (b) missionary students who participate full-time on a voluntary, uncompensated basis in a formal, non-profit program whose mission is to provide religious or charitable work;

The requirements of this Section 2.13(D)(4) shall be deemed to be met during any “medically necessary leave of absence” of the Dependent, provided that such leave does not exceed one year, measured from the first day of the “medically necessary leave of absence,” and provided that coverage for such Dependent would not otherwise terminate under Section 4.13 of this Plan. A “medically necessary leave of absence” means a leave of absence from a postsecondary educational institution or any other

change in enrollment of the Dependent at such institution (e.g., part-time student status) that:

- (a) Commences while such Dependent is suffering from a serious illness or injury; and
 - (b) Is medically necessary, pursuant to a treating physician's written certification.
- (E) A Retiree's Children if such Children:
- (1) Are over age 19; and
 - (2) Are unmarried; and
 - (3) Are principally dependent upon the Retiree as their primary source of financial support at the time the Child would otherwise cease to be eligible because of age; and
 - (4) Are incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap.
- (F) A Domestic Partner's Children if the Domestic Partner is enrolled in the Plan and such Children:
- (1) Satisfy the requirements of (C), (D), or (E) above; and
 - (2) Share the same legal residence as the Employee or Disabled Person.

A Covered Retiree's or covered Domestic Partner's Child is a Dependent only to the extent that each of the conditions under either Subsection (C), (D), (E) or (F) of this Section 2.13 is satisfied. Upon the failure of a Covered Retiree's or a covered Domestic Partner's Child to satisfy any of these conditions, the Child will cease to be a Dependent at the end of the month in which the loss of eligibility occurs.

A Covered Retiree's or a covered Domestic Partner's foster child with respect to whom a welfare agency assumes medical care costs is expressly excluded from the definition of Dependent under this Retiree Medical Plan.

If a Covered Retiree or a covered Domestic Partner's claims a Child as a Dependent under this Section 2.13, the Plan Administrator may require the Covered Retiree to provide proof that each of the conditions under either Subsection (C), (D), (E) or (F) of this Section 2.13 is satisfied.

If a Covered Retiree claims a Child as a Dependent under Subsection (E) of this Section 2.13 (or, similarly, if a covered Domestic Partner claims a Child as a Dependent under (F)), the Covered Retiree (or covered Domestic Partner) must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap. Such proof must be provided before coverage is continued under Subsection (E) or (F) of this Section 2.13. Additionally,

such proof must be provided upon request at such time as the Plan Administrator may reasonably require. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. A Child who is a Dependent under Subsection (D) or (F) of this Section 2.13 is subject to all other provisions of this Retiree Medical Plan.

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

Section 2.14 “Disabled Status” means any period of time during which an Employee met the definition of an Eligible Disabled Person under the Farm Credit Foundations Medical Plan.

Section 2.15 “Domestic Partner” means a person of the same or opposite sex for whom each of the following conditions is met:

- (A) **Age Requirement.** The person is at least age eighteen (18); and
- (B) **Consent to Contract.** The person has attained the legal age to consent to contract according to the laws of the state in which the Retiree and the person reside; and
- (C) **No Blood Relationship.** The Retiree 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 Retiree desired to be married; and
- (D) **Cohabitation.** The Retiree 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
- (E) **No Other Marriage or Domestic Partnership.** Neither the person nor the Retiree is married to any other person, any prior marriages involving the person and/or the Retiree have been legally dissolved, the relationship between the person and the Retiree is exclusive, and there is no other person who is a spousal equivalent or Domestic Partner of either the person or the Retiree; and
- (F) **Common Welfare and Financial Obligations.** The Retiree and the person are jointly responsible for each other’s common welfare and share financial obligations.

A covered Retiree’s domestic partner is a Domestic Partner only to the extent that each of the conditions listed in this Section 2.15 is satisfied. Upon the failure of a covered Retiree’s Domestic Partner to satisfy any of these conditions, the Domestic Partner will cease to be a Domestic Partner on the last day of the month coincident with or next following the date on which the loss of eligibility occurs. If a person was not covered as a Domestic Partner under the Farm Credit Foundations Medical Plan, such

person may not be a Domestic Partner under this Retiree Medical Plan. If a Covered Retiree claims a person as a Domestic Partner under this Section 2.15, the Plan Administrator may require the Covered Retiree to provide proof that each of the conditions listed above in this Section 2.15 is satisfied. The Plan Administrator may require proof of continuing Domestic Partnership status from time to time, but not more than once each year.

Section 2.16 “Eligible Dependent” means a Dependent who satisfies the eligibility conditions of Article III.

Section 2.17 “Eligible Retiree” means a Retiree who satisfies the eligibility conditions of Article III.

Section 2.18 “Employee” means an individual employed by the Employer as a common law employee, excluding the following:

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

Section 2.19 “Employer” means AgriBank, FCB; U.S. AgBank, FCB; Northwest Farm Credit Services; and any other 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 Retiree Medical Plan and the Participation Agreement remains in effect. Pursuant to the terms of the Administrative Agreement, the Plan Sponsor Committee is responsible for handling all settlor functions on behalf of the Employer under this Retiree Medical Plan.

Section 2.20 “Former Ninth Farm Credit District Employer” means an Employer listed in Schedule C of the Administrative Agreement; provided, however, such term shall not include any Western District Association Employer.

Section 2.21 “Former Seventh Farm Credit District Employer” means an Employer listed in Schedule B of the Administrative Agreement.

Section 2.22 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.23 “Insurance Contract” means the individual insurance contract entered into between the Insurer and the Retiree or his/her Dependent(s) who is/are participating in the Age 65 and Older Coverage pursuant to Article VII.

Section 2.24 “Insurer” means the insurance company chosen by the Farm Credit Foundations Plan Sponsor Committee to provide the Age 65 and Older Coverage pursuant to Article VII.

Section 2.25 “Medicare” means all parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act, as amended from time to time.

Section 2.26 “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 Retiree Medical Plan in a manner consistent with the terms of this Retiree Medical Plan.

Section 2.27 “Plan Year” means the fiscal year of this Retiree Medical Plan, the twelve (12) consecutive month period beginning every January 1 and ending the subsequent December 31.

Section 2.28 “Qualifying Termination” means a termination of employment due to a participating Employer’s reorganization. Reorganization includes a merger, acquisition or change in control, which affects the Employee in one or more of the following ways:

- (A) The Employee does not receive an offer of continued employment; and/or
- (B) The Employee experiences an adverse change in status or position as a result of a material diminution in his/her duties, responsibilities, or authority with the Employer; and/or
- (C) The Employee receives an offer of continued employment and such employment entails a decrease in salary; and/or
- (D) The Employee receives an offer of continued employment but it requires relocation of at least 50 miles from the Employee’s current place of employment; and/or
- (E) The Employer terminates (i) a written contract of employment between the Employer and the Employee or (ii) a written “change of control agreement” between the Employer and the Employee, which termination is not expressly authorized by such contract or agreement, or the Employer breaches such contract or agreement, other than an isolated, insubstantial, and inadvertent failure not occurring in bad faith and that is remedied by the Employer within a reasonable period after the Employer’s receipt of notice thereof from the Employee; and/or
- (F) The Employer fails to comply with any material provision (i) of a written contract of employment between the Employer and the Employee or (ii) of a written “change of control agreement” between the Employer and the Employee, which failure has not been cured within the timeframe set forth in such contract or agreement.

Section 2.29 “**Retiree**” means any person who was previously employed by the Employer within the common law definition of an employer/employee relationship. A Retiree does not become eligible for coverage under this Retiree Medical Plan (i.e., does not become an Eligible Retiree) unless and until the Retiree satisfies the eligibility conditions set forth in Article III.

Section 2.30 “**Retiree Medical Plan**” means the Farm Credit Foundations Retiree Medical Plan. The Retiree Medical Plan consists of this Wrap Around Plan Document, the Benefit Description, and the Benefit Schedules which are incorporated by reference and made a part of the Benefit Description.

Section 2.31 “**Retirement Date**” means the date an Employee becomes a Retiree.

Section 2.32 “**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 2.33 “**Under Age 65 Coverage**” means the coverage provided through Article VI of this Retiree Medical Plan.

Section 2.34 “**Western District Association**” means an Employer listed among the Former Eleventh District Associations in Schedule C of the Administrative Agreement.

Section 2.35 “**Wrap Around Plan Document**” means this Retiree Medical Plan document, consisting of the Preamble through Article XV of this Retiree Medical Plan, but not including the Benefit Description or Benefit Schedules attached hereto, which this Wrap Around Plan Document incorporates by reference.

**ARTICLE III
ELIGIBILITY AND PARTICIPATION**

Section 3.01 General Requirements for Coverage. To become a Covered Person under this Retiree Medical Plan, an individual must satisfy each of the following requirements:

- (A) The individual must be either a Retiree or a Dependent; and
- (B) The individual must satisfy the eligibility conditions set forth in this Article III for becoming an Eligible Retiree or Eligible Dependent; and
- (C) The individual must be enrolled in this Retiree Medical Plan in accordance with Article IV; and
- (D) The individual must not have waived coverage pursuant to Section 4.06.

PART A – ELIGIBILITY REQUIREMENTS FOR POST- 2006 RETIREES

Section 3.02 Requirements for a Retiree to Become an Eligible Retiree. A Retiree whose Retirement Date is on or after January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in either Subsection (A), Subsection (B), Subsection (C), or Subsection (D):

- (A) The Retiree, as of his/her Retirement Date, meets each of the following conditions:
 - (1) The Retiree is age 55 or older; and
 - (2) The Retiree has at least ten (10) years of continuous service – whether on active or Disabled Status – with the Employer or another federal Farm Credit System entity, provided that:
 - (a) The service with another federal Farm Credit System entity immediately preceded service with the Employer; and
 - (b) The amount of service accrued during any period of Disabled Status is no greater than the amount of service accrued as an active Employee; and
 - (3) The Retiree was covered under the Farm Credit Foundations Medical Plan on the day immediately prior to his/her Retirement Date.
- (B) The Retiree, as of his/her Retirement Date, meets each of the following conditions:
 - (1) The Retiree is age 50 or older; and

- (2) The Retiree has at least ten (10) years of continuous service – whether on active or Disabled Status – with the Employer or another federal Farm Credit System entity, provided that:
 - (a) The service with another federal Farm Credit System entity immediately preceded service with the Employer; and
 - (b) The amount of service accrued during any period of Disabled Status is no greater than the amount of service accrued as an active Employee; and
 - (3) The Retiree is receiving enhanced pension benefits under a defined benefit plan maintained by the Employer pursuant to a special early retirement program, which adds five (5) years to the actual age of the Retiree and five (5) years to the Retiree’s actual years of service for purposes of computing the Retiree’s benefit under such plan; and
 - (4) The Retiree either experiences a Qualifying Termination or is entitled to receive enhanced pension benefits under the terms and conditions of the defined benefit plan in which the Retiree is participating pursuant to Subsection (3) above.
- (C) The Retiree, as of his/her Retirement Date, meets each of the following conditions:
- (1) The Retiree’s Employer is AgStar Financial Services, ACA (“AgStar”); and
 - (2) The Retiree is age 50 or older; and
 - (3) The Retiree has ten (10) or more years of service with AgStar or another Farm Credit System entity, provided that the service with another federal Farm Credit System entity immediately preceded service with AgStar; and
 - (4) The Retiree is participating in the AgriBank District Retirement Plan; and
 - (5) The Retiree is receiving benefits under the AgStar Financial Services, ACA Supplemental Executive Retirement Plan, as a result of having entered into an Executive Employment Agreement and Change of Control Agreement with AgStar in 2006.
- (D) The Retiree, as of his/her Retirement Date, meets each of the following conditions:
- (1) The Retiree’s Employer is affiliated with U.S. AgBank; and
 - (2) The Retiree either (a) is age 55 or older and has ten (10) or more years of service with a Farm Credit System employer, or (b) satisfies the “rule of 85” by having the sum of his/her age and years of service be equal to or greater than eighty-five (85); and

- (3) The Retiree is not a participant in the Ninth Farm Credit District Pension Plan, but instead is accruing benefits under The Eleventh Farm Credit District Employees' Retirement Plan; and
- (4) The Retiree was covered under the Farm Credit Foundations Medical Plan on the day immediately prior to his/her Retirement Date.

PART B – ELIGIBILITY REQUIREMENTS FOR PRE- 2007 RETIREES

Section 3.03 Retirees from Participating Employers in the Former Ninth Farm Credit District Retiree Group Medical Benefits Plan. A Retiree whose Retirement Date was prior to January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in Subsection (A), Subsection (B), or Subsection (C):

- (A) **Retired Employee Receiving Pension Benefits.** A former employee of an Employer, which had adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:
 - (1) Was age 55 or older on his/her Retirement Date; and
 - (2) Had ten (10) or more years of service with a Farm Credit System employer and had accumulated at least five (5) years of service with a Former Ninth Farm Credit District Employer following his/her last inter-district transfer; and
 - (3) Retired and began to receive benefits under the Ninth Farm Credit District Pension Plan on the first day of the month following his/her Retirement Date; and
 - (4) Was covered under the Ninth Farm Credit District Employee Group Medical Plan on his/her Retirement Date; and
 - (5) Elected to participate in the Ninth Farm Credit District Retiree Group Medical Benefits Plan prior to his/her Retirement Date.
- (B) **Retired Employee Receiving “Enhanced” Pension Benefits.** A former employee of an Employer, which had adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:
 - (1) Was age 50 or older on his/her Retirement Date; and
 - (2) Had fifteen (15) or more years of service with a Farm Credit System employer and had accumulated at least five (5) years of service with a Former Ninth Farm Credit District Employer following his/her last inter-district transfer; and

- (3) Retired and began to receive benefits under the Enhanced Benefits provisions of the Ninth Farm Credit District Pension Plan, as outlined in Section 6.07 of such plan, on the first day of the month following his/her Retirement Date; and
 - (4) Was covered under the Ninth Farm Credit District Employee Group Medical Plan on his/her Retirement Date; and
 - (5) Elected to participate in the Ninth Farm Credit District Retiree Group Medical Benefits Plan prior to his/her Retirement Date.
- (C) **Retired Employee of an Affiliated Employer.** A former employee of an Employer, which had affiliated with the former Ninth Farm Credit District and adopted the Ninth Farm Credit District Retiree Group Medical Benefits Plan, who:
- (1) Had coverage terminated under the retiree medical plan of the former Farm Credit District of the Employer as a result of the Employer's affiliation with the former Ninth Farm Credit District; or
 - (2) Would have been eligible to participate in the retiree medical plan of the former Farm Credit District of the Employer on his/her Retirement Date had the Employer continued to remain affiliated with the former Farm Credit District.

Section 3.04 Retirees from Participating Employers in the Farm Credit Retiree Medical Plan. A Retiree whose Retirement Date was prior to January 1, 2007, is eligible to participate in this Retiree Medical Plan if he/she has satisfied the conditions set forth in Subsection (A), Subsection (B), Subsection (C), or Subsection (D):

- (A) **Seventh Farm Credit District.** A former employee of a Former Seventh Farm Credit District Employer who:
- (1) Was age 55 or older on his/her Retirement Date from the Former Seventh Farm Credit District Employer; and
 - (2) Had ten (10) or more years of service with a Farm Credit System Employer as of his/her Retirement Date; and
 - (3) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
 - (4) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.
- (B) **Farm Credit Services of America.** A former employee of Farm Credit Services of America who satisfies the requirements of Subsection (B)(1), Subsection (B)(2), or Subsection (B)(3) below:

- (1) Was hired prior to January 1, 2003 *and*:
 - (a) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and
 - (b) Had ten (10) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and
 - (c) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
 - (d) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

 - (2) Was hired prior to January 1, 2003 *and*:
 - (a) Was age 40 or older on December 31, 2002; and
 - (b) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and
 - (c) Had five (5) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and
 - (d) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
 - (e) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.

 - (3) Was hired on or after January 1, 2003 and before January 1, 2007, *and*:
 - (a) Was age 55 or older on his/her Retirement Date from Farm Credit Services of America; and
 - (b) Had ten (10) or more years of service with Farm Credit Services of America as of his/her Retirement Date; and
 - (c) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
 - (d) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.
- (C) **Northwest Farm Credit Services.** A former employee of Northwest Farm Credit Services who:
- (1) Was hired prior to January 1, 2007; and

- (2) Was age 55 or older on his/her Retirement Date from Northwest Farm Credit Services; and
 - (3) Had ten (10) or more years of service with Northwest Farm Credit Services as of his/her Retirement Date; and
 - (4) Was covered under the Farm Credit Consolidated Medical Plan on his/her Retirement Date; and
 - (5) Elected to participate in the Farm Credit Retiree Medical Plan as of his/her Retirement Date.
- (D) **Western District Association.** A former employee of a Western District Association who satisfied: (i) either Subsection (D)(1) or Subsection (D)(2); and (ii) Subsection (D)(3); and (iii) Subsection (D)(4).
- (1) Was hired prior to January 1, 2002 and satisfied one of the following subparagraphs:
 - (a) Met the “rule of 85” as of his/her Retirement Date, such that the sum of his/her age and years of service with a Farm Credit System employer is equal to or greater than eighty-five (85); or
 - (b) Was age 65 or older as of his/her Retirement Date from the Western District Association; or
 - (c) Was between the age of 62 and 64, with at least five and one-half (5½) years of service with the Western District Association, as of his/her Retirement Date; or
 - (d) Was age 60 or 61, with at least fifteen (15) years of service with the Western District Association, as of his/her Retirement Date; or
 - (e) Was age 55, with at least ten (10) years of service with the Western District Association, as of his/her Retirement Date.
 - (2) Was hired between January 1, 2002 and December 31, 2006, *and*:
 - (a) Was age 55 or older as of his/her Retirement Date from the Western District Association; and
 - (b) Had ten (10) or more years of service with the Western District Association as of his/her Retirement Date.
 - (3) Was covered under the Farm Credit Consolidated Medical Plan as of his/her Retirement Date; and

- (4) Elected to participate in the Farm Credit Retiree Medical Plan prior to his/her Retirement Date.

PART C – ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Section 3.05 Requirements for a Dependent to Become an Eligible Dependent. A Dependent of an Eligible Retiree is eligible to be enrolled in this Retiree Medical Plan (i.e., becomes an Eligible Dependent) if each of the following conditions are met:

- (A) The Eligible Retiree is enrolled (i.e., is a Covered Retiree) in this Retiree Medical Plan; and
- (B) The Dependent is not ineligible for coverage under this Retiree Medical Plan pursuant to the provisions of Sections 3.06; and
- (C) If the Dependent met the definition of a “dependent” under the Farm Credit Foundations Medical Plan on the Eligible Retiree’s Retirement Date, the Dependent was covered as a dependent under such plan on that date.

Section 3.06 Restrictions on Dependents’ Coverage Under this Plan. The following rules apply to all Dependents of an Eligible Retiree:

- (A) **May Not be a Covered Dependent of More Than One Retiree.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent of more than one Covered Retiree.
- (B) **May Not be Covered Under the Farm Credit Foundations Medical Plan.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent of a Covered Retiree while, at the same time, being covered under the Farm Credit Foundations Medical Plan as either an “employee” (as that term is defined in the Farm Credit Foundations Medical Plan) or as a “covered dependent” of an “employee” (as those terms are defined in the Farm Credit Foundations Medical Plan).

For example, if the Spouse of an Eligible Retiree is also an Employee covered under the Farm Credit Foundations Medical Plan, the Eligible Retiree and his/her Spouse must choose one of the following options:

- (1) The Eligible Retiree may enroll in this Retiree Medical Plan and his/her Spouse (along with any other Eligible Dependents) may be covered as a Covered Dependent under this Retiree Medical Plan; or

- (2) The Eligible Retiree may enroll in this Retiree Medical Plan and the Employee-Spouse may continue to be covered under the Farm Credit Foundations Medical Plan. Dependents who are eligible for coverage may be covered with either (a) the Eligible Retiree under this Retiree Medical Plan, or (b) the Employee-Spouse under the Farm Credit Foundations Medical Plan, assuming that the conditions for coverage under the applicable plan are otherwise satisfied.
- (C) **May Not be Both a Covered Retiree and a Covered Dependent.** No person may be covered under this Retiree Medical Plan as both a Covered Retiree and a Covered Dependent.

For example, if the Spouse of an Eligible Retiree is also an Eligible Retiree, the Eligible Retiree and his/her Spouse must choose one of the following options:

- (1) Each Spouse may enroll separately with the result that each Spouse will be a Covered Retiree; or
- (2) Either Spouse may enroll as the Covered Retiree and the other Spouse, along with any other eligible Dependents, may be covered as a Covered Dependent.
- (D) **May Not be a Member of the Armed Forces of Any Country.** No Dependent may be covered under this Retiree Medical Plan as a Covered Dependent if such Dependent is a member of the armed forces of any country.

Section 3.07 Special Proof Rules Applicable to Dependent Children. The following rules apply to Dependent Children of an Eligible Retiree:

- (A) **Proof of Dependent Status.** If a Covered Retiree claims a Child as a Dependent, the Plan Administrator may require the Covered Retiree to provide whatever documentation is necessary to prove that the Child meets the conditions of being a Dependent.
- (B) **Proof that Child is Incapable of Employment or is Totally Disabled.** If a Covered Retiree claims a Child as a Dependent because the Child is incapable of employment or is totally disabled, the Covered Retiree must provide proof that the Child is incapable of self-sustaining employment by reason of mental retardation, mental illness, or physical handicap, or that the Child is totally disabled. Such proof must be provided before coverage is continued. Additionally, such proof must be provided periodically thereafter so long as coverage under the Retiree Medical Plan continues. The Plan Administrator may require proof of continuing incapacity from time to time, but not more than once each year. Failure to submit required proof or to allow medical or psychiatric examination of the Child will be considered affirmative proof that the Child is no longer incapacitated or Totally Disabled.

PART D – OTHER ELIGIBILITY RULES

Section 3.08 Rehired Retirees. A Covered Retiree who becomes reemployed by the Employer will continue to be an Eligible Retiree and may continue to be covered under this Retiree Medical Plan if:

- (A) Prior to becoming reemployed by the Employer, the former Employee was an Eligible Retiree under Section 3.01; and
- (B) The Employee is not eligible to participate in the Farm Credit Foundations Medical Plan.

Section 3.09 Retirees of Affiliating Employers. In the case of any Retiree of a Farm Credit System entity that becomes an Employer under this Retiree Medical Plan in accordance with Section 2.19 on or after January 1, 2007, the determination of whether such Retiree should be eligible for coverage under this Retiree Medical Plan shall be made in accordance with the provisions of the affiliation agreement entered into between AgriBank or U.S. AgBank and such Farm Credit System Employer, provided such provisions have been approved by the Plan Sponsor Committee. If such a Retiree is determined to be eligible for coverage under this Retiree Medical Plan, the Retiree shall become a Covered Retiree in this Retiree Medical Plan as of the date set forth in the affiliation agreement.

**ARTICLE IV
TIME & DURATION OF COVERAGE**

Section 4.01 General Rule Regarding Time and Duration of Coverage. If a Retiree or Dependent satisfies the eligibility requirements for coverage set forth in Article III, his/her coverage under this Retiree Medical Plan will commence, and continue to remain in effect, in accordance with the provisions of this Article IV.

PART A – RETIREE COVERAGE

Section 4.02 Commencement of Coverage for Pre-2007 Retirees. A Retiree whose Retirement Date was prior to January 1, 2007, and who satisfied the eligibility requirements for coverage set forth in Part B of Article III, shall be covered under this Retiree Medical Plan without any further necessary action, effective January 1, 2007. Such Retiree's enrollment in his/her prior retiree medical plan shall constitute a valid enrollment for this Retiree Medical Plan.

Section 4.03 Enrollment by Post-2006 Retirees. A Retiree whose Retirement Date is on or after January 1, 2007, and who satisfies the eligibility requirements for coverage set forth in Parts A or D of Article III, shall be covered under this Retiree Medical Plan, effective on the date specified in Section 4.04, if he/she makes a timely election for coverage by completing and returning the proper enrollment forms to the Plan Administrator no later than sixty (60) days following his/her Retirement Date.

Section 4.04 Commencement of Coverage for Post-2006 Retirees. A Retiree who satisfies the conditions set forth in Section 4.03 shall be covered under this Retiree Medical Plan on the first day or the sixteenth day of the month coincident with or next following his/her Retirement Date.

Section 4.05 Duration of Retiree Coverage. A Retiree's coverage as a Covered Retiree under the Retiree Medical Plan shall terminate on the earliest of:

- (A) The date this Retiree Medical Plan terminates; or
- (B) The end of the period for which a required Retiree contribution was last paid on or before the date on which it was due; or
- (C) The date on which the Retiree becomes covered as a Covered Dependent under this Retiree Medical Plan or as an Employee's Covered Dependent under the Farm Credit Foundations Medical Plan; or
- (D) The date on which the Employer's participation in the Administrative Agreement is terminated; or
- (E) The Retiree's death.

Section 4.06 Waiver of Coverage. If an Eligible Retiree fails to make a timely election for coverage under this Retiree Medical Plan within sixty (60) days of his/her Retirement Date, the eligibility and option to attain coverage hereunder will be irretrievably lost, and coverage will never again be available. Additionally, eligibility for coverage under this Retiree Medical Plan will be permanently and irretrievably lost if, after having been covered under this Retiree Medical Plan, a Covered Retiree allows his/her coverage to lapse.

PART B – DEPENDENT COVERAGE

Section 4.07 General Enrollment Period for Eligible Dependents. Except as otherwise provided in this Part B of Article IV, an Eligible Dependent of a Covered Retiree may participate in this Retiree Medical Plan only if a timely election for coverage is made on his/her behalf by completing and returning the proper enrollment forms to the Plan Administrator by the later of:

- (A) The date the Covered Retiree makes a timely election for his/her own coverage pursuant to Section 4.03; or
- (B) Thirty-one (31) days after the date on which the Eligible Dependent first comes within (or again comes within) the definition of an Eligible Dependent.

Section 4.08 Special Enrollment Period for Dependents Previously Covered Under Health Insurance Plans. The occurrence of either of the following two events described in Subsections (A) and (B) below shall result in a Special Enrollment Period of limited duration for the Dependent (other than a Domestic Partner) of a Retiree who is not already enrolled and covered under this Retiree Medical Plan:

- (A) **Loss of Other Health Coverage.** A Covered Retiree's Dependent (other than a Domestic Partner) for whom coverage was not elected under this Retiree Medical Plan because such Dependent was covered under another group health plan or had other health insurance coverage may still enroll in this Retiree Medical Plan if such alternative coverage terminated because of an event specified in either Subsection (1) or (2) below:
 - (1) There was a loss of eligibility for such alternative coverage. A loss of eligibility includes the following:
 - (a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, reduction in the number of hours of employment, or exhaustion of the maximum COBRA period; or
 - (b) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits; or

- (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; or
- (d) Loss of eligibility for Medicaid coverage or coverage under a state's children's health insurance program ("SCHIP"), on or after April 1, 2009.

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

or

- (2) Employer contributions toward such other coverage ceased;

The special enrollment period expires 31 days after the alternative coverage terminates, except that the Special Enrollment Period expires 60 days after the coverage described in Section 4.08(A)(1)(d) above terminates. Coverage elected during this special enrollment period will commence on the later of the date that the alternative coverage terminates or the date on which the Retiree or Dependent timely submits his/her proper enrollment forms to the Plan Administrator.

- (B) **Eligibility for a State Premium Assistance Subsidy Under the Medical Plan from Medicaid or SCHIP.** A Dependent may enroll in this Retiree Medical Plan if, on or after April 1, 2009, he/she becomes eligible for a state premium assistance subsidy under this Retiree Medical Plan from Medicaid or a SCHIP.

The Special Enrollment Period expires 60 days after becoming eligible for the state premium assistance subsidy. Coverage elected during this Special Enrollment Period will commence on the later of the date the Dependent becomes eligible for the state premium assistance subsidy or the date on which the Retiree or Dependent timely submits his/her proper enrollment forms to the Plan Administrator.

Section 4.09 Commencement of Eligible Dependents' Coverage. Except as expressly provided otherwise in this Article IV, the effective date of an Eligible Dependent's coverage under this Retiree Medical Plan shall be governed by the following rules:

- (A) **General Rule.** If a Covered Retiree has one or more Eligible Dependents on the date he/she commences coverage under this Retiree Medical Plan, and he/she elects the "Family Coverage" option (or the "Retiree Plus Spouse Coverage" option or the "Retiree Plus Child(ren) Coverage" option), the enrolled Eligible Dependents' coverage under this Retiree Medical Plan shall become effective on the date on which coverage is effective for such Covered Retiree; and

- (B) **Exception for Special Enrollment Period.** If a Covered Retiree enrolls his/her Eligible Dependent in this Retiree Medical Plan pursuant to the Special Enrollment Period provisions set forth in Section 4.08, the enrolled Eligible Dependent's coverage under this Retiree Medical Plan shall become effective on the date of the relevant event that triggered the Special Enrollment Period pursuant to Section 4.08(A).

Section 4.10 Newly-Elected Coverage for Newly-Acquired (or Newly-Eligible) Non-Newborn Dependents. If a Covered Retiree acquires an Eligible Dependent (other than a newborn infant described in Section 4.11 below or a Domestic Partner) after the Covered Retiree's effective date of coverage, or if the Covered Retiree's Spouse or Child comes into conformity with the definition of an Eligible Dependent after the Covered Retiree's effective date of coverage, and the Retiree thereupon or thereafter elects the "Family Coverage" option (or the "Retiree Plus Spouse Coverage" option or the "Retiree Plus Child(ren) Coverage" option), the enrolled Eligible Dependent's coverage under this Retiree Medical Plan shall become effective on the date the Covered Retiree acquired the Eligible Dependent, provided that the enrollment/status change form has been received by the Plan Administrator prior to such date. If the requisite form is received by the Plan Administrator after such date, then coverage shall become effective on the first day of the month next following the date that the form is received by the Plan Administrator. In all events, however, the enrollment/status change form must be received by the Plan Administrator no later than thirty-one (31) days after the date such Dependent qualifies as an Eligible Dependent under this Retiree Medical Plan. If the enrollment/status change form is not received within thirty-one (31) days after the date such Dependent qualifies as an Eligible Dependent, such Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

Section 4.11 Newly-Elected Coverage for Newborn Dependents Acquired by Birth or Adoption. If a Covered Retiree acquires a newborn Eligible Dependent, by way of birth or adoption, after the Covered Retiree's effective date of coverage, and thereupon or thereafter elects the "Family Coverage" option (or the "Retiree Plus Spouse Coverage" option or the "Retiree Plus Child(ren) Coverage" option), such Eligible Dependent's coverage under this Retiree Medical Plan shall become effective as of the date of such Eligible Dependent's birth or adoption, as applicable, provided that the enrollment/status change form and payment of the premium rate for dependent coverage are received by the Plan Administrator no later than thirty-one (31) days after the date of the Eligible Dependent's birth or adoption, as applicable. If, after thirty-one (31) days, the Covered Retiree has not elected a coverage option sufficient to include the new Eligible Dependent, enrolled such Eligible Dependent, and paid the appropriate premium, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

Section 4.12 Extension of Existing Family Coverage. If a Covered Retiree, who currently has the "Family Coverage" option (or the "Retiree Plus Spouse Coverage" or "Retiree Plus Child(ren) Coverage" options), extends his/her coverage to include an additional Eligible Dependent (whether newly-acquired (other than a Domestic Partner or newly-eligible), the effective date of such Eligible Dependent's coverage will be governed by the following rules:

- (A) **Newly-Acquired Newborn Dependents by Birth or Adoption.** If the Covered Retiree has the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option) and thereafter acquires a newborn Eligible Dependent by way of birth or adoption, such Eligible Dependent’s coverage under this Retiree Medical Plan shall become effective as of the date of such Eligible Dependent’s birth or adoption, as applicable, provided that the enrollment/status change form is received by the Plan Administrator no later than thirty-one (31) days after the date of the Eligible Dependent’s birth or adoption, as applicable. If the requisite enrollment/status change form has not been received by the Plan Administrator within thirty-one (31) days of the Eligible Dependent’s birth or adoption, as applicable, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.
- (B) **Dependents Newly-Eligible for Reasons Other than Birth or Adoption.** If the Covered Retiree has the “Family Coverage” option (or the “Retiree Plus Spouse Coverage” option or the “Retiree Plus Child(ren) Coverage” option) and, thereafter, the Covered Retiree’s Spouse or Child first comes (or again comes) into conformity with the definition of an Eligible Dependent for reasons other than birth or adoption, the Spouse or Child’s coverage under this Retiree Medical Plan becomes effective on the date such individual first came (or again came) into conformity with the definition of an Eligible Dependent, provided that the enrollment/status change form is received by the Plan Administrator no later than thirty-one (31) days after such date. If the requisite enrollment/status change form has not been received by the Plan Administrator within thirty-one (31) days of such date, the Eligible Dependent will be precluded from receiving coverage under this Retiree Medical Plan.

Section 4.13 Duration of Dependent Coverage – General Rule. Except as expressly provided otherwise in Sections 4.14 and 4.16 below, a Covered Dependent’s coverage under the Retiree Medical Plan shall terminate on the earliest of:

- (A) The date this Retiree Medical Plan terminates; or
- (B) The date of termination of coverage of the Covered Retiree through whom the Covered Dependent is receiving coverage; or
- (C) The last day of the month coincident with or next following the date the Covered Dependent no longer meets the Retiree Medical Plan’s definition of a Dependent, or no longer satisfies the Retiree Medical Plan’s eligibility requirements; or
- (D) The end of the month in which the Covered Dependent enters active service in the armed forces of any country, except temporary active service of two (2) weeks or less; or
- (E) The end of the period for which a Covered Retiree’s required contribution was last paid on or before the date on which it was due; or

- (F) The date upon which the Covered Dependent becomes covered as a Covered Retiree under this Retiree Medical Plan or as a covered employee under the Farm Credit Foundations Medical Plan.

Section 4.14 Covered Dependent Spouse's Coverage Following Death of Covered Retiree. In the event of the death of a Covered Retiree, a Covered Dependent Spouse or covered Domestic Partner – regardless of his/her age – may maintain his/her coverage under the Retiree Medical Plan by paying the applicable premium. In this circumstance, the coverage of the Covered Dependent Spouse or the covered Domestic Partner would *not* be subject to the continuation of coverage provisions set forth in Part C of this Article IV. Instead, the Covered Dependent Spouse or covered Domestic Partner shall assume the same rights and obligations under this Retiree Medical Plan to which the Covered Retiree would be subject had he/she not pre-deceased the Covered Dependent-Spouse or covered Domestic Partner; provided, however, a surviving Covered Dependent-Spouse or covered Domestic Partner may not obtain coverage under this Retiree Medical Plan for a newly-acquired Dependent Spouse or Domestic Partner.

PART C – CONTINUATION OF COVERAGE

Section 4.15 Continuation of Coverage – Age 65 and Older Coverage. No continuation coverage shall be provided to Covered Persons as part of the Age 65 and Older Coverage of this Retiree Medical Plan.

Section 4.16 Continuation of Coverage – Under Age 65 Coverage. If a “qualified beneficiary” loses (or would lose) coverage under the Under Age 65 Coverage of this Retiree Medical Plan as a result of a “qualifying event,” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a continuation of coverage election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Retiree Medical Plan is subject to the following rules:

- (A) **Qualified Beneficiary.** For purposes of this Section, a “qualified beneficiary” means any Covered Person who was covered under the Under Age 65 Coverage of this Retiree Medical Plan, as set forth in Article VI, on the day before the “qualifying event.” The term “qualified beneficiary” shall also include any Dependent Children who are born to or acquired by a Covered Retiree or Covered Dependent Spouse or Domestic Partner while he/she is continuing his/her coverage.
- (B) **Qualifying Event.** For purposes of this Section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Retiree Medical Plan as a result of such an event:
- (1) Death of the Covered Retiree;
 - (2) Divorce or legal separation of the Covered Retiree and the Covered Retiree's Covered Dependent Spouse; or

- (3) A Covered Dependent no longer satisfies the conditions for being covered as a Dependent of the Covered Retiree.
- (C) **Election to Continue Coverage.** Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the Plan Administrator and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.
- (D) **Premium for Continuation Coverage.** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.
- (E) **Maximum Coverage Period – General Rule.** Except as provided otherwise in Subsection (F) below, the maximum period of time for which continuation coverage will be provided shall be thirty-six (36) months.
- (F) **Maximum Coverage Period for Non-Spouse Surviving Dependents.** A Covered Dependent (other than the Covered Retiree’s Spouse or Domestic Partner) who elects continuation coverage following the Covered Retiree’s death may continue such coverage under this Retiree Medical Plan until the earliest of the following:
 - (1) The death of the Covered Dependent; or
 - (2) The end of the month in which the Covered Dependent ceases to meet the definition of Dependent; or
 - (3) The date the Covered Dependent becomes eligible for and enrolled in benefits under another group health plan; or
 - (4) The end of a period for which a required contribution was last paid.
- (G) **Termination of Qualified Beneficiary’s Continuation Coverage.** A qualified beneficiary’s continuation coverage may be terminated prior to the expiration of the maximum coverage period upon the occurrence of any of the following events:
 - (1) The Employer terminates this Retiree Medical Plan and no longer offers coverage under a group health plan to any of its Retirees; or
 - (2) The qualified beneficiary becomes covered under another group health plan; or
 - (3) The qualified beneficiary becomes eligible for Medicare based on his/her attainment of age 65; or
 - (4) A required premium is not paid within the applicable deadline (including any applicable grace period).

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

ARTICLE V COVERAGE OPTIONS

Section 5.01 General Rule. The coverage that is available under this Retiree Medical Plan is dependent on the age of the Covered Person.

- (A) **Under Age 65.** If the Covered Person is under the age of 65, the coverage available to such person is the coverage provided pursuant to the provisions of Article VI (Under Age 65 Coverage).
- (B) **Age 65 or Older.** If the Covered Person is age 65 or older, the coverage available to such person is the coverage provided pursuant to the provisions of Article VII (Age 65 and Older Coverage).
- (C) **Determination of Age.** For purposes of determining the coverage that is available under this Retiree Medical Plan, a Covered Person is considered to be age 65 as of the first day of the month in which he/she attains age 65.
- (D) **Attaining Age 65 During Middle of Plan Year.** If a Covered Person attains age 65 during the middle of a Plan Year, the Covered Person shall no longer be covered under Article VI as of the first day of the month in which the Covered Person attains age 65. In this event, the Covered Person must instead be covered under the coverage provided pursuant to Article VII.

Section 5.02 Special Rule for Covered Retiree Age 65 or Older with Covered Dependents Under Age 65. If a Covered Retiree is age 65 or older but one or more of his/her Covered Dependents is under age 65, the following rules apply:

- (A) The Covered Retiree and any Covered Dependents who are age 65 and older will be covered under the Age 65 and Older Coverage of this Retiree Medical Plan as set forth in Article VII. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan.
- (B) Any Covered Dependents who are under age 65 will be covered under the Under Age 65 Coverage of this Retiree Medical Plan as set forth in Article VI. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan. For purposes of calculating premiums, the oldest of any such Covered Dependents shall be treated as if he/she is the Covered Retiree and the remaining Covered Dependents, if any, shall be treated as if they are Covered Dependents of the oldest such Covered Dependent.
- (C) The total premium for the coverage being provided under this Retiree Medical Plan as a result of this Section 5.02 will be equal to the premium for the Under Age 65 Coverage plus the premium for the Age 65 and Older Coverage.

Section 5.03 Special Rule for Covered Retiree Under Age 65 with Covered Dependents Age 65 or Older. If a Covered Retiree is under age 65 but one or more of his/her Covered Dependents is age 65 or older, the following rules apply:

- (A) The Covered Retiree and any Covered Dependents who are under age 65 will be covered under the Under Age 65 Coverage of this Retiree Medical Plan as set forth in Article VI. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan.
- (B) Any Covered Dependents who are age 65 and older will be covered under the Age 65 and Older Coverage of this Retiree Medical Plan as set forth in Article VII. Premiums for this portion of the coverage shall be calculated as if these persons were the only persons being covered under this Retiree Medical Plan. For purposes of calculating premiums, the oldest of any such Covered Dependents shall be treated as if he/she is the Covered Retiree and the remaining Covered Dependents, if any, shall be treated as if they are the Covered Dependents of the oldest such Covered Dependent.
- (C) The total premium for the coverage being provided under this Retiree Medical Plan will be equal to the premium for the Under Age 65 Coverage plus the premium for the Age 65 and Older Coverage.

Section 5.04 Special Rules for Certain Civil Service Retirees. A Covered Retiree participating in the Civil Service Retirement System (“Civil Service Retiree”), who is not enrolled in Medicare Part A, may be covered under the Under Age 65 Coverage of this Retiree Medical Plan. Such coverage will be secondary to Medicare. If and when the Civil Service Retiree does become enrolled in Medicare Part A and is approved for coverage by the Insurer, the Civil Service Retiree will no longer be eligible for coverage under the Under Age 65 Coverage of this Retiree Medical Plan but will instead be required to enroll in the Age 65 and Older Coverage if he/she wishes to continue his/her coverage under this Retiree Medical Plan.

ARTICLE VI
COVERAGE: MEDICAL BENEFITS FOR PERSONS UNDER AGE 65

Section 6.01 Medical Benefits. Medical benefits under this Article VI are identical to those described in, and shall be paid pursuant to the terms of, the current Benefit Description, which is attached to this Wrap Around Plan Document. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under this Retiree Medical Plan shall be determined from the Benefit Description; provided, however, that should there be any contradictions between the Benefit Description and this document, this document will control.

Section 6.02 Election to Participate.

- (A) **Benefit Options.** An Eligible Retiree may choose from multiple benefit options as set forth in the Benefit Description and the Benefit Schedules attached thereto. The election applies to the Eligible Retiree as well as to any Eligible Dependent(s) for whom coverage is elected.
- (B) **Enrollment/Status Change Forms.** As set forth in Article IV, if an Eligible Retiree elects coverage under this Retiree Medical Plan (including coverage for his/her Eligible Dependent(s)), he/she must timely complete and return all requisite enrollment/status change forms to the Plan Administrator.
- (C) **Ability to Change Benefit Options.** Covered Retirees make an annual decision regarding their medical coverage under this Retiree Medical Plan and, subject to the exceptions in Subsection (C)(1) and (C)(2) below, may change their benefit option only during the annual enrollment period, to be effective at the beginning of the next Plan Year. Benefit options may be changed outside of the annual enrollment period if:
 - (1) The Covered Retiree acquires a new (or newly) Eligible Dependent as set forth in Article IV; or
 - (2) The Covered Retiree elects coverage, pursuant to Section 4.08, for his/her Eligible Dependent who was previously covered another health insurance plan.

Section 6.03 Premiums for Coverage. The Covered Person is responsible for payment of the applicable premium for coverage under the Under Age 65 Coverage of this Retiree Medical Plan, subject to any subsidy, to which the Covered Person may be entitled. The amount of the applicable premium may change from time to time.

ARTICLE VII
COVERAGE: MEDICAL BENEFITS FOR PERSONS AGE 65 AND OLDER

Section 7.01 Medical Benefits. The benefits provided under this Article VII are identical to those described in, and shall be paid pursuant to the terms of, the individual Insurance Contract between the Insurer and the Covered Person who has elected coverage under such Insurance Contract pursuant to this Article VII. The provisions of the Insurance Contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by the Insurer. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Article VII shall be determined from the Insurance Contract. The Covered Person shall fully bear any and all risk of insolvency on the part of the Insurer.

Section 7.02 Effective Date of Age 65 and Older Coverage. The effective date of coverage for Covered Retirees and/or Covered Dependents in the Age 65 and Older Coverage of this Retiree Medical Plan is as follows:

- (A) **Previously Covered as part of Under Age 65 Coverage.** A Covered Retiree or Covered Dependent who was previously covered as part of the Under Age 65 Coverage of this Retiree Medical Plan must elect coverage as part of the Age 65 and Older Coverage of this Retiree Medical Plan no later than the first day of the month in which such Covered Retiree or Covered Dependent attains age 65. If such coverage is timely elected, it will be effective on the first day of the month in which such Covered Retiree or Covered Dependent attains age 65.
- (B) **Retirement Date After Age 65.** A Retiree who, at the time of his/her Retirement Date, is age 65 or older and who (i) satisfies the eligibility requirements for coverage set forth in Article III, and (ii) timely elects to enroll in this Retiree Medical Plan pursuant to Section 4.03, will be enrolled in the Age 65 and Older Coverage. Such coverage will be effective on the first day of the month or the sixteenth day of the month that is coincident with or next following such Eligible Retiree's Retirement Date.
- (C) **Dependent Age 65 or Older at Time of Eligible Retiree's Retirement Date.** An Eligible Dependent who, at the time he/she is initially enrolled in this Retiree Medical Plan, is age 65 or older, will be enrolled in the Age 65 and Older Coverage. Such coverage will be effective as set forth in Part B of Article IV.

Section 7.03 Coverage Options under the Insurance Contract. Prior to attaining age 65, and at such other times as the Plan Administrator may designate, a Covered Person must select the coverage option under the Insurance Contract that he/she desires.

- (A) **Selection of Coverage Options.** Each Covered Person must choose his/her own coverage option.

- (B) **Underwriting Requirement.** There is no underwriting requirement when a Covered Person first becomes eligible for coverage under this Article VII. Any other underwriting requirements are reflected in the underlying Insurance Contract.

Section 7.04 Premiums for Coverage. The premiums for coverage will be determined by the Insurer and may change from time to time. If a Covered Person enrolls in this Retiree Medical Plan after attaining age 65, he/she may pay a higher premium for coverage. The Covered Person is responsible for payment of the applicable premium, reduced by the subsidy, if any, to which he/she is entitled.

Section 7.05 Claims Administrator. The Claims Administrator for all benefits payable under this Article VII is the Insurer. As Claims Administrator, the Insurer has full discretionary authority to make all determinations regarding the payment of benefit Claims in accordance with the terms of the Insurance Contract. All decisions of the Claims Administrator shall be final and binding.

Section 7.06 Coordination of Benefits. The Coordination of Benefits provisions in the Insurance Contract are hereby incorporated by reference.

Section 7.07 Third Party Liability/Subrogation Provisions. The third party liability and subrogation provisions in the Insurance Contract are hereby incorporated by reference.

**ARTICLE VIII
HIPAA MEDICAL PRIVACY AND SECURITY**

PART I – PREAMBLE

Section 8.01 Purpose and Effective Date. This HIPAA Medical Privacy and Security Article is adopted in response to the provisions of the Medical Privacy and Security Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 8.02 Application of Amendment. This Article shall supersede the provisions of the Retiree Medical Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 8.03 Relationship to Other Group Health Plans. The Retiree Medical Plan is part of an “organized health care arrangement” (“OHCA”) with the following plans maintained by the Employer:

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

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

PART II – DISCLOSURE OF PHI TO THE EMPLOYER

Section 8.04 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by Part II of this Article VIII, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information or electronic Protected Health Information to the Employer.

Section 8.05 Definitions. For purposes of this Article VIII, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in 45 C.F.R. Parts 160 and 164.

- (A) “**Breach**” means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach.”

- (1) Any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of the Group Health Plan or Business Associate (as defined in 45 C.F.R. § 160.103) if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such employee or individual, respectively, with the Group Health Plan or the Business Associate, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the Privacy or Security Rules;
 - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan or Business Associate to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the Privacy or Security Rules; and
 - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.
- (B) **“De-identified Health Information”** means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone, and fax numbers, and Social Security numbers.
- (C) **“Electronic Media”** means
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
 - (2) Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

- (D) **“Electronic Protected Health Information” (“e-PHI”)** means PHI that is transmitted or maintained in electronic media.
- (E) **“Individually Identifiable Health Information”** means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse; and
 - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
 - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (F) **“Plan Administration Functions”** means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan that is not part of the same OHCA as the Retiree Medical Plan.
- (G) **“Protected Health Information” (“PHI”)** means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (H) **“Security Incident”** (as defined in 45 C.F.R. § 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (I) **“Security Rule”** shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Parts 160 and 164, subpart C.
- (J) **“Summary Health Information”** means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in 45 C.F.R. § 164.514(b)(2)(ii) has been removed, except that geographical locations may be described using a five digit ZIP code.
- (K) **“Unsecured Protected Health Information” (“Unsecured PHI”)** means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 8.06 Enrollment/Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been unenrolled in, the medical coverage provided under the Group Health Plan.

Section 8.07 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (A) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any Business Associates of the Group Health Plan; and
- (B) Overseeing the adjudication of benefit Claims, including the responsibility to provide coverage upon the initial submission of Claims and the disposition of any appeals that are filed with respect to Claims that are denied in whole or in part; and
- (C) Overseeing the coordination of benefits and pursuing and/or responding to Claims for subrogation; and
- (D) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits; and
- (E) Detecting fraud or abuse; and
- (F) Determining whether charges for services are appropriate or justified; and
- (G) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance; and
- (H) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part; and
- (I) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate; and
- (J) Providing assistance, upon request, to Covered Persons in addressing and resolving problems that they may encounter with the approval and payment of Claims that have been submitted on their behalf; and

- (K) Reporting corporate finances with respect to current and projected healthcare costs; and
- (L) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (M) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 8.07 is subject to the provisions of Section 8.08.

Section 8.08 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 8.07, the Employer agrees to do the following:

- (A) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law; and
- (B) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI; and
- (C) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer; and
- (D) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. This includes reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s) and the Department of Health and Human Services (the "HHS") may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications; and
- (E) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out of pocket in full; and

- (F) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in 45 C.F.R. § 164.524; and
- (G) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by 45 C.F.R. § 164.526; and
- (H) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by 45 C.F.R. § 164.528; and
- (I) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements; and
- (J) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (K) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
 - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI; and
 - (2) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and
 - (3) Report to the Group Health Plan any Security Incident of which it becomes aware.
- (L) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III of this Article VIII; and
- (M) Provide a certification to the Group Health Plan as required by Section 8.09.

Section 8.09 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 8.08 of Part II of this Article VIII.

PART III – ADMINISTRATIVE SAFEGUARDS

Section 8.10 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III of Article VIII. The Employer will ensure that the provisions of this Part III are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article VIII does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 8.11 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Covered Persons: (a) those Employees of the Employer who have the responsibility for administering the benefit programs of the Employer, including, but not limited to, all Employees who serve on or are appointed by the Farm Credit Foundations Trust Committee and all Employees in the benefits section of the AgriBank Benefits Department; (b) members of the Farm Credit Foundations Trust Committee; and (c) the Internal Counsel of the Farm Credit Foundations Trust Committee and his/her support staff in the legal department, but only for the limited purposes of ensuring investigation of and responding to complaints alleging violations of the policies and procedures established by the Employer.

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

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

Section 8.12 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 8.13 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III of Article VIII, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

**ARTICLE IX
ADMINISTRATION OF THE RETIREE MEDICAL PLAN**

Section 9.01 Plan Administrator. The Plan Administrator is the Farm Credit Foundations Trust Committee. The Plan Administrator is responsible for the administration of the Retiree Medical Plan. The Plan Administrator has the full discretionary authority to administer the Retiree Medical Plan, subject to the requirements of law. Except as otherwise provided by law or otherwise delegated in this Retiree Medical Plan, all decisions of the Plan Administrator are final and binding on all parties. For this purpose, the Plan Administrator, in addition to such other powers as the law may provide, has the power to:

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

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

Section 9.02 Plan Must Be Nondiscriminatory. The Plan Administrator will administer this Retiree Medical Plan in a nondiscriminatory manner so that all persons similarly situated will receive substantially similar treatment.

ARTICLE X
CLAIMS PROCEDURES FOR SELF-FUNDED MEDICAL AND
PRESCRIPTION DRUG BENEFIT OPTIONS – UNDER AGE 65 COVERAGE

PART I – GENERAL PROVISIONS

Section 10.01 Claims Administrator. In the Under Age 65 Coverage of this Retiree Medical Plan, the Claims Administrator with respect to any Claim for benefits (other than prescription coverage) under a self-funded PPO option – as set forth in the Benefit Description – is BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, IL, 60680-4112. (Relevant information also may be found at www.bcbsil.com/foundations.) The Claims Administrator with respect to any Claim for prescription benefits is CVS Caremark, P.O. Box 686005, San Antonio, TX, 78265-6005. (Relevant information also may be found at www.caremark.com.) Both Claims Administrators may be contacted by telephone at 1-866-563-8366.

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

Section 10.02 Duties of the Claims Administrator. The applicable Claims Administrator shall have the discretionary power and authority to perform the following duties and responsibilities:

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

- (E) Adopt such rules and procedures relating to the administration of Claims as it deems necessary or desirable; and
- (F) Be responsible for all Claims administration reporting and disclosure requirements for the Retiree Medical Plan under the law; and
- (G) Receive from the Employer, Employees, Participants and other persons such information as shall be necessary for the proper administration of Claims under the Retiree Medical Plan; and
- (H) Maintain all Claims administration records of the Retiree Medical Plan.

The applicable Claims Administrator shall also handle appeals for benefits in accordance with this Article X and the applicable Benefit Schedule referenced in the Benefit Description.

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

Section 10.03 Claims for Medical Benefits (Other Than Prescriptions). The Claims procedures outlined in Part II of this Article X shall apply to all Claims for medical benefits and services other than prescription benefits. Prescription benefit Claims procedures are governed by Part III of this Article X.

Section 10.04 How to File a Claim.

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

The Claim shall be processed by the Claims Administrator when it receives the Claim. The benefit payment shall be sent directly to the Hospital or Physician. The Claims Administrator shall provide the Covered Person a statement informing him/her of the amount of the Claim paid on his/her behalf. If necessary, the Claims Administrator shall send the payment directly to the Covered Person or, if applicable, in the case of a “qualified medical child support order,” to the designated representative as it appears on the Claims Administrator’s records.

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

- (1) **Claim Form.** A Claim form must be completed. Claim forms are available from the Plan Administrator or from the Claims Administrator's office; and
- (2) **Copies of Bills.** Copies of all bills to be considered for benefits must be attached to the Claim form. The bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge; and
- (3) **Mailing Address.** The completed Claim form with attachments must be mailed to BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, Illinois 60680-4112.

Section 10.05 Claims Procedures. Claims made for benefits under the Retiree Medical Plan shall be processed in accordance with the following procedures:

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

- (D) **Payment of Claims.** The Retiree Medical Plan shall pay benefits with respect to covered expenses, as determined by the Claims Administrator, typically within thirty (30) days of the receipt of all the necessary information on the Claim for benefits. By virtue of any such payment, the Employer, the Farm Credit Foundations Trust Committee, and the Retiree Medical Plan shall be released from further liability for any amount so paid.
- (E) **Denial of Claims.** If a Claim for benefits is denied in whole or part, the Claims Administrator shall, within a reasonable period of time, but no later than thirty (30) days after receipt of the Claim and all necessary information related thereto, notify the Claimant of the denial of the Claim. This period, however, may be extended by fifteen (15) days, provided that the Claims Administrator determines that such an extension is necessary and notifies the Claimant of the extension before the end of the initial 30-day period. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall have at least forty-five (45) days from receipt of the notice to provide the specified information.

Such notice of denial:

- (1) Shall be in writing; and
 - (2) Shall be written in a manner calculated to be understood by the Claimant; and
 - (3) Shall contain --
 - (a) The specific reason(s) for denial of the Claim; and
 - (b) A specific reference to the pertinent Retiree Medical Plan provisions upon which the denial is based; and
 - (c) A description of any additional material or information necessary for the Claimant to perfect the Claim, along with an explanation why such material or information is necessary; and
 - (d) An explanation of the Retiree Medical Plan's Claim review procedure.
- (F) **First Level Appeal of Claim Denial to Claims Administrator.** Upon denial of a Claim in whole or in part, the Claimant or his/her duly authorized representative shall have 180 days within which to file with the Claims Administrator a written request for a review of such denial, whereupon:
- (1) The Claims Administrator shall act as promptly as is practicable, ordinarily within 60 days; and

- (2) The Claimant or his/her duly authorized representative, pending said review, shall be permitted at all reasonable hours to review the pertinent documents and shall also be entitled to submit issues, comments and additional medical information in writing.

Such request for review shall be sent to BlueCross BlueShield of Illinois, P.O. Box 805107, Chicago, Illinois 60680-4112.

The Claims Administrator may honor telephone requests for information, but such inquiries shall not constitute a request for review.

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

- (6) An explanation by the Claimant as to why the Claimant believes the reasoning of the Claims Administrator in denying the Claim is incorrect; and why the Claimant believes the Claim is properly payable under the terms and conditions of the Retiree Medical Plan.

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

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

PART III – CLAIMS FOR PRESCRIPTION BENEFITS

Section 10.06 Claims for Prescriptions Benefits. The procedures outlined in Part III of this Article X shall apply only to Claims for Prescription benefits. Claims for other medical benefits and services are governed by Part I of this Article X.

Section 10.07 How to File a Claim. In order to obtain Prescription benefits under this Retiree Medical Plan, a Claim must be filed with the Claims Administrator. The procedures for filing the Claim with the Claims Administrator vary, depending on whether the Covered Person's Prescription is filled at a Mail Order Pharmacy, a Network Retail Pharmacy, or a Non-Network Retail Pharmacy (as those terms are defined in the Benefit Schedules).

- (A) **Mail Order Pharmacy.** If a Covered Person chooses to have his/her Prescription filled through a Mail Order Pharmacy, he/she must complete a Participant Profile/Order Form, which shall be made available by the Plan Administrator. This form must then be sent, along with any required documents and any applicable co-payment or co-insurance, to the Claims Administrator's Mail Order Pharmacy at the following address: CVS Caremark, P.O. Box 659529, San Antonio, Texas, 78265-9529. The Claims Administrator shall process the Claim after the Mail Order Pharmacy has filled the Prescription.

- (B) **Network Retail Pharmacy.** If a Covered Person chooses to have his/her Prescription filled at a Network Retail Pharmacy, the Covered Person must present his/her Medical Plan identification card to the Network Retail Pharmacy at the time of purchase. After the Covered Person has paid any applicable co-payment or co-insurance, the Network Retail Pharmacy will file a Claim on the Covered Person's behalf. The Claims Administrator shall process the Claim after receiving it from the Network Retail Pharmacy.

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

- (C) **Non-Network Retail Pharmacy.** If the Covered Person chooses to have his/her Prescription filled at a Non-Network Retail Pharmacy, the Covered Person must pay the full cost of the Prescription to the Non-Network Retail Pharmacy and then file a Claim for reimbursement with the Claims Administrator.

- (D) **Claim Reimbursement Submissions.** A Covered Person seeking reimbursement for Prescription benefits from the Claims Administrator must complete a Prescription Drug Claim form and return it to the Claims Administrator.

(1) **Claim Forms.** Prescription Drug Claim forms shall be made available by the Plan Administrator.

(2) **Required Receipts.** The Prescription Drug Claim form must be accompanied by a receipt for each Prescription medication. Each receipt must show: the patient's name, the Prescription number, the Pharmacy name and address, the name and strength of the drug, the quantity of the drug, an indication whether the prescribing Physician directed that the Prescription be dispensed as written, the Physician's name or DEA number, the date of purchase, and the total charge for the Prescription.

(3) **Mailing Address.** The completed Prescription Drug Claim Form must be mailed to CVS Caremark, Inc., P.O. Box 686005, San Antonio, Texas, 78268-6005.

Section 10.08 Claims Procedures. Claims made for Prescription benefits under the Retiree Medical Plan shall be processed in accordance with the following procedures:

- (A) **Claims.** A Covered Person seeking reimbursement for Prescription benefits must submit a Prescription Drug Claim form (along with any required receipts or other documentation) to the Claims Administrator within twelve (12) months of the date of purchase.

- (B) **Payment of Claims.** The Retiree Medical Plan shall pay benefits with respect to covered Prescription expenses, as determined by the Claims Administrator, typically within thirty (30) days of the receipt of all necessary Claim reimbursement information.
- (C) **Denial of Claims.** If a Claim for Prescription benefits is denied in whole or part, the Claims Administrator shall, within a reasonable period of time, but no later than thirty (30) days after receipt of the Claim and all necessary information related thereto, notify the Claimant of the denial of the Claim.

Such notice of denial:

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

- (3) The Prescription Claim Appeal form and all supporting materials must be submitted to the Claims Administrator via mail or fax machine (toll free). The contact information is as follows:

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

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

- (1) Limited Appeal Rights. This second level of appeal is available only for denied Claims for Prescription benefits that require pre-authorization or pre-approval. For all other Prescription benefit denied Claim appeals, the Claims Administrator's denial of the Claimant's initial appeal is final and binding.
- (2) Required Information in Appeal. If a Claimant makes a second appeal to the Claims Administrator, the Claimant or his/her duly authorized representative shall submit all necessary information to evaluate the Claim within 30 days of the initial denial of the Claim by the Claims Administrator. Such information shall include the following:
 - (a) The name of the Claimant; and
 - (b) The amount and date of the expense(s) incurred; and
 - (c) The specific medical condition or symptom upon which the Claim is based; and
 - (d) The Prescription medication – drug name, strength, and quantity/dosage – for which authorization or approval is being requested; and
 - (e) The specific terms of the Retiree Medical Plan that the Claimant is relying upon in support of his/her assertion that the Claim is properly payable under the terms and conditions of the Retiree Medical Plan; and
 - (f) An explanation by the Claimant as to why the Claimant believes the initial decision of the Claims Administrator in denying the Claim is incorrect; and why the Claimant believes the Claim is properly payable under the terms and conditions of the Retiree Medical Plan.

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

- (G) **Access to Relevant Information.** Upon timely request, a Claimant shall be provided reasonable access to, and copies of, documents, medical records, and other information relevant to his/her appeal of the denied Claim for Prescription benefits.

- (H) **Decision on Review by the Claims Administrator/Medical Review Board.** A decision shall be made by the third party medical review board no more than 90 days after the request for review, and any request for additional information, is received by the Claims Administrator or board. Any decision by the medical review board denying the Claim in whole or in part shall be in writing and shall include specific reasons for the decision and specific references to the Retiree Medical Plan provisions on which the decision is based. The decision of the medical review board shall be final and binding.

PART IV – LITIGATION OF DENIED CLAIM APPEALS

Section 10.09 Litigation of Claim. Prior to initiating legal action concerning a Claim for benefits in any state or federal court against this Retiree Medical Plan, any trust used in conjunction with this Retiree Medical Plan, and/or the Plan Administrator, a Claimant must first exhaust the administrative remedies provided by the Claims Administrator in accordance with this Article X. If the Claims Administrator, acting pursuant to the Retiree Medical Plan's written Claims procedure, makes a final written determination denying a Claim, the Claimant, to preserve the Claim, must file an action with respect to the denied Claim not later than 180 days following the date of the Claims Administrator's final determination.

ARTICLE XI
CLAIMS PROCEDURES FOR HMO AND/OR FULLY INSURED PPO OPTIONS IN
UNDER AGE 65 COVERAGE

Section 11.01 Claims Administrator. The Claims Administrator(s) of any HMO and/or fully insured PPO options in the Under Age 65 Coverage of this Retiree Medical Plan is set forth in the applicable HMO or fully insured PPO Insurance Contract. The Claims Administrator(s) is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of benefit Claims in accordance with the terms of the applicable group contract. Except as provided by law, all decisions of the Claims Administrator(s) shall be final and binding.

Section 11.02 How to File a Claim. Any Claim for benefits shall be filed in accordance with the Claims procedures set forth in the applicable HMO option or fully insured PPO option.

Section 11.03 Claims Procedures. The procedures for appealing any denial of a benefit Claim are set forth in the applicable HMO option or fully insured PPO option and must be followed accordingly.

ARTICLE XII
CLAIMS PROCEDURES FOR AGE 65 AND OLDER COVERAGE

Section 12.01 Claims Procedures. The claims procedures for coverage under the Age 65 and Older Coverage of this Retiree Medical Plan are set forth in the individual Insurance Contract issued by the Insurer to the Covered Retiree and/or his/her Covered Dependent(s).

ARTICLE XIII
SUBROGATION AND REIMBURSEMENT OF THE RETIREE MEDICAL PLAN

Section 13.01 Age 65 and Older Coverage. The subrogation and reimbursement provisions related to the Age 65 and Older Coverage of this Retiree Medical Plan are set forth in the individual Insurance Contract issued by the Insurer to the Covered Retiree and/or his/her Covered Dependent(s).

Section 13.02 Under Age 65 Coverage – HMOs and Fully Insured PPO Options. The subrogation and reimbursement provisions related to the HMO and fully insured PPO options in the Under Age 65 Coverage of this Retiree Medical Plan are set forth in the applicable HMO or fully insured PPO Insurance Contract.

Section 13.03 Under Age 65 Coverage – Self-Funded PPO Options. The subrogation and reimbursement provisions related to the self-funded PPO options in the Under Age 65 Coverage of this Retiree Medical Plan are set forth in this Article XIII.

Section 13.04 Subrogation/Reimbursement Rights of the Plan.

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

Section 13.05 Amount of Recovery. The Retiree Medical Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Retiree Medical Plan. The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a Claim or reimbursement. In addition, these rights take priority over the Covered Person's, or his/her assignee's, right to be made whole.

Section 13.06 Condition of Payment. By accepting benefits from the Retiree Medical Plan, a Covered Person or his/her assignee agrees to the following:

- (A) The Retiree Medical Plan may require a Covered Person, assignee, or someone legally qualified and authorized to act for such person, to agree to Sections 13.04 and 13.05 in writing and to execute any and all other instruments reasonably necessary for the Retiree Medical Plan to assert its rights under these Sections; and
- (B) Any amounts recovered by such individual or by the Retiree Medical Plan by judgment, settlement, or otherwise will be applied first to reimburse the Retiree Medical Plan; and
- (C) The Retiree Medical Plan shall be subrogated to all Claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Retiree Medical Plan; and
- (D) At the Retiree Medical Plan's request, a Covered Person or his/her assignee must take any action, give information, and/or execute instruments required by the Retiree Medical Plan, in its discretion, in order to aid the Retiree Medical Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the Retiree Medical Plan may withhold benefits, services, payments, or credits due under the Retiree Medical Plan.

**ARTICLE XIV
TERMINATION AND AMENDMENT OF THE RETIREE MEDICAL PLAN**

Section 14.01 Termination and Amendment. The Plan Sponsor Committee may amend or terminate this Retiree Medical Plan at any time in accordance with the procedures established by the Administrative Agreement, which procedures are hereby incorporated by reference. Any approved change to the Retiree Medical Plan shall be made through a written instrument. Upon termination of this Retiree Medical Plan, the Employer shall give notice of the termination to all individuals then receiving benefits under this Retiree Medical Plan and any other affected person.

ARTICLE XV MISCELLANEOUS

Section 15.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 15.02 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 Retiree Medical Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Retiree Medical Plan or under his/her job duties related to this Retiree Medical Plan. This indemnification does not cover such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person, provided this paragraph shall not limit any indemnification of the Employee pursuant to any indemnification provisions of the bylaws of the Employer of the Employee or pursuant to any indemnification insurance held by such Employer.

Section 15.03 Information. The Plan Administrator may require each Covered Person to supply such information and sign such documents as may be necessary to implement this Retiree Medical Plan.

Section 15.04 Legal Service. Process can be served on the Retiree Medical Plan by directing such legal service to the Claims Administrator and/or the Plan Administrator.

Section 15.05 Limitation of Rights. Neither the establishment of this Retiree Medical Plan, nor any amendment, nor the payment of any benefits gives any Covered Person or any other person a legal or equitable right against the Employer or the Plan Administrator, nor any rights of continued employment.

Section 15.06 Limitation on Liability. A Retiree Medical Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Retiree Medical Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 15.07 Named Fiduciary. The named fiduciary of this Retiree Medical Plan shall be the Farm Credit Foundations Trust Committee ("Trust Committee"). The Trust Committee shall have complete authority to control and manage the operation and administration of this Retiree Medical Plan. If so designated in a contract between the Trust Committee and a Claims Administrator, the Claims Administrator shall also be a named fiduciary of this Retiree Medical Plan to the extent designated in such contract. In addition, the Insurer providing and making benefit payments for a particular insured benefit shall be named fiduciary of this Retiree Medical Plan with respect to that benefit.

Section 15.08 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 Covered Person under this Retiree Medical Plan will be excludable from the Covered Person'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 Covered Person. It shall be the obligation of each Covered Person to determine whether each payment under the Retiree Medical Plan is excludable from the Covered Person's gross income for Federal and state income tax purposes, and to notify the Employer if the Covered Person has reason to believe that any such payment is not so excludable.

Section 15.09 Nonalienation of Benefits. Benefits payable under this Retiree Medical Plan are not subject in any manner to transfer or assignment, unless such benefits are transferred or assigned (a) for the purpose of providing payment for services provided under the terms of this Retiree Medical Plan, and/or (b) as expressly permitted under the terms of this Retiree Medical Plan; any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Retiree Medical Plan, is void. The Employer is not in any manner liable for, nor subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Retiree Medical Plan.

Section 15.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in this Retiree Medical Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Retiree Medical Plan on a prospective basis only. No person shall be allowed to enter the Retiree Medical Plan on a retroactive basis.

Section 15.11 Rights to Employer's Assets. No Covered Person 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 Retiree Medical Plan, and then only to the extent of the benefits payable under the Retiree Medical Plan to such Covered Person or beneficiary. The Employer will make all payments of benefits this Retiree Medical Plan provides solely from the assets of the Employer, and the Plan Administrator is not liable for payment of benefits in any manner.

Section 15.12 Source of Funds. The Retiree Medical Plan shall be funded by direct payments from the Farm Credit Foundations Welfare Benefit Trust. The trust shall be funded by the Employer, the Retiree and/or their Covered Dependents subject to all of the provisions of this Retiree Medical Plan.

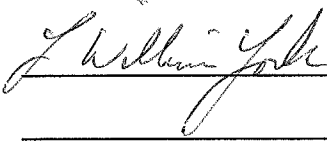
Section 15.13 State Law. The laws of the State of Delaware will determine all questions arising with respect to the provisions of this Retiree Medical Plan except to the extent superseded by Federal law.

FARM CREDIT FOUNDATIONS
RETIREE MEDICAL PLAN

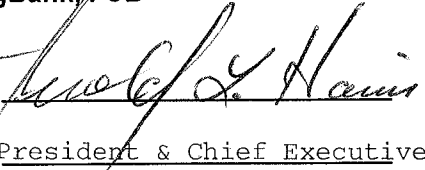
Execution Page

IN WITNESS WHEREOF, the Employer and Associations (through execution of Participating Employer Agreements) have executed this Farm Credit Foundations Retiree Medical Plan effective January 1, 2007.

AgriBank, FCB

By: 
Title: _____
Date: _____, 2006

U.S. AgBank, FCB

By: 
Title: President & Chief Executive Officer
Date: October 16, 2006

**HIPAA CERTIFICATION BY THE PLAN SPONSOR COMMITTEE TO
THE FARM CREDIT FOUNDATIONS RETIREE MEDICAL PLAN**

WHEREAS, this certification relates to the amended and restated Farm Credit Foundations Retiree Medical Plan (the "Plan");

WHEREAS, the Plan is effective January 1, 2007;

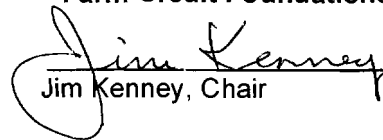
WHEREAS, the former plan documents had been amended as necessary to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii);

WHEREAS, this restated Plan has also been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii);

NOW, THEREFORE, in consideration of the premises and the mutual covenants contained herein, the Farm Credit Foundations Plan Sponsor Committee (the "Plan Sponsor") certifies that the Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). The Plan Sponsor further certifies that it agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of Protected Health Information by the Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

Farm Credit Foundations Plan Sponsor Committee

By:


Jim Kenney, Chair

Date:

11/08/07

**BENEFIT DESCRIPTION FOR THE
FARM CREDIT FOUNDATIONS RETIREE MEDICAL PLAN
UNDER AGE 65 COVERAGE**

The medical care benefits offered under the Under Age 65 Coverage of this Retiree Medical Plan are described in this Benefit Description and attached schedules and are provided pursuant to Section 6.01 of the Wrap Around Plan Document. This Benefit Description is a part of and incorporated into the Wrap Around Plan Document of the Retiree Medical Plan. This Benefit Description incorporates by reference the terms and conditions of each benefit option listed below and set forth in an attached schedule.

All Eligible Retirees may choose to participate in one of the following three self-funded benefit options:

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

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

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

In addition to the options listed above, depending on the Employer's location, certain HMO options may also be available. This Retiree Medical Plan incorporates those HMO contracts by reference.

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

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