Coverage Available to You and Your Dependents

- Medical Plans
- Dental Plans
- Vision Plan
- Tax-Advantage Accounts
- Other Employer-Provided Benefits
- Optional Benefits

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Table of Contents

Eligibility..................................................................................................................................................... 2
Enrollment Periods ...................................................................................................................................... 2
Benefits at a Glance .................................................................................................................................. 3
Medical Plans ............................................................................................................................................. 5
Wellness Benefits ...................................................................................................................................... 10
Prescription Drug Coverage ..................................................................................................................... 11
Dental Plans .............................................................................................................................................. 14
Vision Plan ............................................................................................................................................... 17
Tax-Advantage Accounts ............................................................................................................................ 18
Life and Disability Insurance ..................................................................................................................... 23
Retirement/401(k) ....................................................................................................................................... 26

Benefits Value Proposition

Your employer believes in offering worry-free benefits that provide safety, security and peace of mind for you and your family. Through comprehensive Total Rewards, access to financial tools and support, and personal services, our benefits demonstrate the belief that employees’ health and financial well-being are of primary importance. No matter where on life’s continuum you are or what life transition you experience, the benefits provided support your health care needs and you are guided along the right path for retirement.

The information provided in this Benefits Guide is intended to be a general summary of benefits provided by Farm Credit Foundations. In the event that any information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers participating in Farm Credit Foundations intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.
Eligibility

You are eligible for benefits if you are employed by a Farm Credit employer that participates in the Farm Credit Foundations benefit plans and you are:

- A full-time employee (regularly scheduled to work at least 30 hours per week)
- A part-time employee who is eligible for benefits (regularly scheduled to work 20 to 29 hours per week)

Eligible Dependents

Eligible dependents include:

- Spouse* (determined by the state in which you are married) or domestic partner** (domestic partner and common law spouse)
- Children up to their 26th birthday regardless of marital or student status (coverage will run through the end of the month)
- Unmarried children age 26 and older who are physically or mentally challenged and depend on you for support; child must be incapable of self-sustaining employment because of a physical or mental disability

For plan purposes, child(ren) means:

- Your own, legally adopted or stepchild
- Children of a domestic partner as long as your domestic partner is enrolled in coverage
- Child whose coverage is required by a Qualified Medical Child Support Order (QMCSO)
- Child other than the above with a court document granting guardianship

*For plan purposes, a spouse means:

Common law spouse, legally married same-sex spouse, legally married opposite-sex spouse. Spouse does not include civil unions, registered partnerships or other legal relationships.

**For plan purposes, a domestic partner means:

Two unmarried adults at least 18 years of age of the same or opposite sex that are not related by blood who have lived together for more than six months in an exclusive committed relationship of mutual caring and financial support. Dependent benefits for domestic partners are available under the medical, dental and vision plans. An affidavit will be required if you elect to cover a domestic partner under your medical, dental, and or vision plan.

Enrollment Periods

Farm Credit Foundations benefit plans operate on a calendar year basis, from Jan. 1 to Dec. 31. Many of the plans are offered through a cafeteria plan which allows enrollment or changes only during special enrollment periods.

New Employee Enrollment Period

Your new employee enrollment period is the first 45 days of hire. Benefits will be effective the 1st or 16th day of the month on or following enrollment. If you do not enroll within 45 days of hire, you will automatically be enrolled in the employer-provided benefits (Basic Employee Term Life and Accidental Death and Dismemberment, Business Travel Accident, Long-Term Disability Insurance). Once enrolled, your election is irrevocable and you must wait until the next Annual Enrollment period unless you experience a qualified status change.

Annual Enrollment Period

The Annual Enrollment period each year is generally the first two weeks in November. During this period, you have the opportunity to review your benefits and make changes. An election filed during the Annual Enrollment period is effective Jan. 1***, and applies throughout the next year.

Special Enrollment Periods

If you meet the requirements for changing one or more of your pre-tax elections during the year, the 31-day period immediately thereafter is a special enrollment period.
Qualified Status Change
You may make mid-year election changes if you have a qualified status change:

- Marriage, divorce or legal separation
- Change in domestic partner relationship
- Birth, adoption or placement for adoption
- Death of your spouse or dependent
- Loss or reinstatement of dependent status
- Significant change in your spouse's/partner's coverage
- Loss of you or your dependents' group coverage due to layoff or termination

If you have a qualified status change and would like to change your coverage, you must submit a status change form within 31 days of the qualified event (60 days from date of birth, adoption, or placement of adoption). Your benefit changes will be effective the date of the event. Any changes made to coverage must be consistent with the qualified status change under IRS Section 125.

*** Life Insurance will become effective upon approval from the vendor and evidence of insurability may be required. Review the information in the Life Insurance section for more information.

Eligibility or Loss of Eligibility Under Medicaid or a State’s Children’s Health Insurance Program
If you, your spouse or your dependent becomes eligible for state premium assistance under a group health plan from Medicaid or a state children’s health program, you have the right to drop your Farm Credit Foundations medical coverage or drop a dependent without waiting for the next Annual Enrollment period.

You must submit a status change form within 60 days after becoming eligible under Medicaid or the state’s program.

If you, your spouse or your dependent(s) lose eligibility under Medicaid or a state children’s health insurance program, you have the right to enroll for medical coverage under the Farm Credit Foundations group medical plan without waiting for the next Annual Enrollment period. You must submit a status change form within 60 days of the loss of other coverage.

Benefits at a Glance
Some benefits are employer-provided, which means your employer pays the entire cost for you. Other benefits are employer-subsidized, which means your employer will pay a substantial portion of the cost of your coverage. Additional benefits are optional—you pay the full cost, but you save money by participating in group coverage provided by your employer.

Pre-Tax Plan Options
- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Health Savings Accounts
Employer Provided Benefits

- **Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance**
  You automatically receive employer-provided coverage equal to one times your total compensation.

- **Business Travel Accident Insurance**
  You automatically receive coverage equal to three times your total compensation.

- **Long-Term Disability (LTD) Insurance**
  You are automatically enrolled in coverage that provides 66 2/3% of your monthly total compensation in the event you become disabled and unable to work.

Employer Subsidized Benefits

- **Medical Coverage**
  Select from three levels of PPO coverage including a Consumer Choice PPO plan with a Health Savings Account (HSA). Depending on your work location, you may also have an HMO plan available. Your premiums are paid on a pre-tax basis.

- **Dental Coverage**
  Choose between two PPO options: Basic Plan and Comprehensive Plan. Your premiums are paid on a pre-tax basis.

- **Defined Contribution/401(k) Plan**
  Company-matching funds are in addition to your contributions.

Optional Benefits

- **Vision Plan**
  Coverage for eye exams, lenses, frames and contact lenses. Receive discounts on certain procedures. You pay for vision coverage on a pre-tax basis.

- **Tax-Advantage Accounts**
  Contribute to one or more accounts available on a pre-tax basis:
  - Health Savings Account (HSA)
  - Health Care Flexible Spending Account (FSA)
  - Dependent Care Flexible Spending Account (FSA)
  - Limited Purpose Health Care Flexible Spending Account (FSA)

- **Optional Basic Employee Term Life and Accidental Death & Dismemberment (AD&D) Insurance**
  Elect coverage for an additional one times your total compensation. You pay the full cost on an after-tax basis.

- **Group Universal Life (GUL) Insurance**
  Purchase benefits up to 10 times your total compensation for yourself and up to $250,000 for your spouse. You can also take advantage of the added benefit of building long-term savings via the cash accumulation fund option. You pay the full cost on an after-tax basis.

- **Dependent Child(ren) Life**
  Purchase up to $25,000 in life insurance for each eligible dependent child paid on an after-tax basis.

- **Voluntary Accidental Death & Dismemberment (AD&D) Insurance**
  Elect coverage for you and/or your family for up to 10 times your total compensation to a maximum of $750,000. You pay on an after-tax basis.
Claim Filing Deadline
Claims must be submitted within 12 months from the date of service for medical, dental and vision to be considered. The claims filing deadline for the Health Care Flexible Spending Account (FSA), Dependent Care Flexible Spending Account (FSA), Limited Purpose Health Flexible Spending Account (FSA) is March 31 of the following calendar year for dates of service in the previous calendar year.

Medical Plans

You can choose between three different medical options for you and your family:
- Consumer Choice PPO Plan (This plan is a qualified high deductible health plan.)
- Standard PPO Plan
- Premium PPO Plan

All three are Preferred Provider Organization (PPO) options administered by Blue Cross and Blue Shield of Illinois (BCBSIL). BCBSIL has a large network of providers. To locate a participating provider in your area you can find a provider directory on www.BCBSIL.com/foundations or by calling BCBSIL at 1-866-563-8366.

The PPO plan from Blue Cross and Blue Shield gives you freedom of choice, flexibility, a broad range of benefit options and access to a large independently contracted provider network. There is no need to select a primary care physician because you can choose a doctor whenever you need care. You do not need a referral to see a specialist or to get another opinion about a medical condition. The provider choice is always yours.

When you receive care from a PPO network provider, there are no claim forms to complete and no balance billing because contracting PPO providers have agreed to accept BCBS’s negotiated rates as payment in full. If applicable, once you meet the annual deductible, there are no upfront payments for medical services with the exception of applicable copayments, coinsurance and charges for non-covered services.

When you receive care from a non-contracted provider, the provider may bill Blue Cross and Blue Shield a dollar amount in excess of the amount allowable for payment. If you choose to see a non-contracted provider, you may be responsible for any amount in excess of the allowable amount for a given service. Blue Cross and Blue Shield pays non-contracted provider claims based on Medicare reimbursement rates. If you plan to see a non-contracted physician, you should ask your physician to submit a predetermination of benefits for any service to determine if covered and the cost.
Consumer Choice PPO Plan
The Consumer Choice PPO Plan is a qualified high deductible health plan (HDHP) that when combined with a Health Savings Account (HSA) provides insurance coverage and a tax-advantage way to help save for future health care expenses.

- **Deductibles:** The Consumer Choice PPO plan has a $2,700 annual deductible for employee coverage or $5,450 annual deductible for all other tiers. One family member or a combination of family members can satisfy the family deductible and the full family deductible must be met before post-deductible benefits are paid.

- **Coinsurance:** Once the deductible is met the Consumer Choice PPO plan will pay 100% of covered expenses from in-network providers or 60% of covered expenses from out-of-network providers.

- **Annual Out-of-Pocket Maximums:** Your maximum annual out-of-pocket expenses from in-network providers for the plan year is $2,700 for employee-only coverage and $5,450 for all other tier levels (employee + spouse, employee + child(ren) or family). Out-of-network annual out-of-pocket maximum is $5,400 for employee only and $10,900 for all other tier levels. Once you meet the out-of-pocket maximum, the plan will pay 100% of eligible expenses.

- **Office Visit Charges:** Under the Consumer Choice PPO plan, office visits are subject to your deductible. Copays do not apply for the Consumer Choice PPO plan – you are responsible for the entire office visit charge until you have satisfied the deductible.

- **Prescription Drug Coverage (administered by CVS Caremark):** Under the Consumer Choice PPO plan, prescription drugs are subject to your deductible. Copays do not apply for the Consumer Choice PPO plan. You are responsible for payment of 100% of the cost of prescription drugs until you have satisfied the deductible.

### Cost of Consumer Choice PPO Plan

<table>
<thead>
<tr>
<th>Coverage Tiers</th>
<th>You Pay</th>
<th>Your Employer Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$0</td>
<td>$464</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$18</td>
<td>$916</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$14</td>
<td>$854</td>
</tr>
<tr>
<td>Family</td>
<td>$34</td>
<td>$1,306</td>
</tr>
</tbody>
</table>

### Deductibles for Consumer Choice PPO Plan
The deductibles that apply to you depend on the coverage level you selected.

**Coverage for an Individual**
- If you elect coverage for yourself, the individual deductible applies to you. You must pay for covered medical services for yourself until the deductible has been satisfied.
- The plan will not begin to pay for benefits until you meet the individual deductible.

**Coverage for an Individual and One or More Dependents**
- If you have family coverage, the entire family deductible must be met before the plan pays benefits for any covered individuals.
- The family deductible must be met by at least one or a combination of covered individuals before the plan begins to pay benefits.
Standard PPO Plan

- **Deductibles:** The Standard PPO plan has a $1,000 per individual/$2,000 per family annual deductible. The combination of deductible expenses for the entire family will not exceed $2,000.

- **Coinsurance:** Once you have met the deductible, the plan will pay at 80% of covered expenses from in-network providers or 60% of covered expenses from out-of-network providers.

- **Annual Out-of-Pocket Maximums:** Your annual out-of-pocket maximum, including deductible, is $3,000 in-network/$4,000 out-of-network for individual and $6,000 in-network/$8,000 out-of-network for employee + spouse, employee + child(ren) and family coverage. Once you meet the out-of-pocket maximum, the plan will pay 100% of eligible expenses. Note that you will continue to pay copay and ineligible expenses.

- **In-Network Office Visit Copay:** You will pay 35% of an office visit charge. The 35% copay for office visits does not count toward the deductible or out-of-pocket maximum requirements. Out-of-network office visit charges are paid at 60% after deductible.

- **Prescription Drug Coverage (administered by CVS Caremark):** Prescription drugs are not subject to your deductible or coinsurance. Instead, you have a copay for each prescription. Prescription drug copays do not count toward your deductible or annual out-of-pocket maximum.

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Cost of Standard PPO Plan

<table>
<thead>
<tr>
<th>Coverage Tiers</th>
<th>You Pay</th>
<th>Your Employer Pays</th>
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</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$51</td>
<td>$464</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$164</td>
<td>$916</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$149</td>
<td>$854</td>
</tr>
<tr>
<td>Family</td>
<td>$262</td>
<td>$1,306</td>
</tr>
</tbody>
</table>

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Deductibles for Standard PPO Plan

The deductibles that apply to you depend on the coverage level you selected and are applied to eligible services rendered each calendar year. The deductibles under the PPO Plans start over each Jan. 1.

**Coverage for an Individual**

- If you elect coverage for yourself, the individual deductible applies to you. You must pay for covered medical services for yourself until the deductible has been satisfied.

- The plan will not begin to pay for benefits until you meet the individual deductible.

**Coverage for an Individual and One or More Dependents**

- If you elect coverage for yourself and one or more eligible dependents, a family deductible applies to all as a single-family unit.

- You must pay for covered medical services until any combination of two or more members of your family meet the family deductible.

- If, however, you pay for covered medical services for any covered member of your family and meet an individual deductible, the plan will start paying for benefits for that covered family member.

- The individual deductible helps to limit what you have to pay if one person in the family uses more health care than the rest of the family.

- Any one or more of the other covered members of your family can then meet the rest of the family deductible. After that, the plan will pay for benefits for the rest of the family members.
## Premium PPO Plan

- **Deductibles:** The Premium PPO plan has a $450 per individual/$900 per family annual deductible. The combination of deductible expenses for the entire family will not exceed $900.

- **Coinsurance:** Once you have met the deductible, the plan will pay at 80% of covered expenses from in-network providers or 60% of covered expenses from out-of-network providers.

- **Annual Out-of-Pocket Maximums:** Your annual out-of-pocket maximum, including deductible, is $1,800 in-network/$2,200 out-of-network for individual and $3,600 in-network/$4,400 out-of-network for employee + spouse, employee + child(ren) and family coverage. Once you meet the out-of-pocket maximum, the plan will pay 100% of eligible expenses. Note that you will continue to pay copay and ineligible expenses.

- **In-Network Office Visit Copay:** You will pay 35% of an office visit charge. The 35% copay for office visits does not count toward the deductible or out-of-pocket maximum requirements. Out-of-network office visit charges are paid at 60% after deductibles are satisfied.

- **Prescription Drug Coverage (administered by CVS Caremark):** Prescription drugs are not subject to your deductible or coinsurance. Instead, you have a copay for each prescription. Prescription drug copays do not count toward your deductible or annual out-of-pocket maximum.

### Cost of Premium PPO Plan

#### Full-Time Monthly Medical Plan Rates

<table>
<thead>
<tr>
<th>Coverage Tiers</th>
<th>You Pay</th>
<th>Your Employer Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$183</td>
<td>$464</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$443</td>
<td>$916</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$408</td>
<td>$854</td>
</tr>
<tr>
<td>Family</td>
<td>$668</td>
<td>$1,306</td>
</tr>
</tbody>
</table>

### Deductibles for Premium PPO Plan

The deductibles that apply to you depend on the coverage level you selected and are applied to eligible services rendered each calendar year. The deductibles under the PPO Plans start over each Jan. 1.

#### Coverage for an Individual

- If you elect coverage for yourself, the individual deductible applies to you. You must pay for covered medical services for yourself until the deductible has been satisfied.
- The plan will not begin to pay for benefits until you meet the individual deductible.

#### Coverage for an Individual and One or More Dependents

- If you elect coverage for yourself and one or more eligible dependents, a family deductible applies to all as a single-family unit.
- You must pay for covered medical services until any combination of two or more members of your family meet the family deductible.
- If, however, you pay for covered medical services for any covered member of your family and meet an individual deductible, the plan will start paying for benefits for that covered family member.
- The individual deductible helps to limit what you have to pay if one person in the family uses more health care than the rest of the family.
- Any one or more of the other covered members of your family can then meet the rest of the family deductible. After that, the plan will pay for benefits for the rest of the family members.
<table>
<thead>
<tr>
<th>Highlights of PPO Medical Plans</th>
<th>Premium Plan</th>
<th>Standard Plan</th>
<th>Consumer Choice Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Existing Condition Exclusion</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expenses</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Deductible</td>
<td>Individual: $450</td>
<td>Individual: $1,000</td>
<td>Individual: $2,700</td>
</tr>
<tr>
<td></td>
<td>Family: $900</td>
<td>Family: $2,000</td>
<td>Family: $5,450</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Includes deductible)</td>
<td>Individual: $1,800</td>
<td>Individual: $3,000</td>
<td>Individual: $2,700</td>
</tr>
<tr>
<td></td>
<td>Family: $3,600</td>
<td>Family: $6,000</td>
<td>Family: $5,400</td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Coinsurance Paid After Deductible (Applies to all professional services except noted below.)</td>
<td>You Pay 20%</td>
<td>You Pay 40%</td>
<td>You Pay 20%</td>
</tr>
<tr>
<td>Office Visit Copays (Copays do not apply to deductible or out-of-pocket maximum)</td>
<td>You Pay 35%</td>
<td>Subject to Deductible and Coinsurance</td>
<td>You Pay 35%</td>
</tr>
<tr>
<td>Lab Work/Professional Services</td>
<td>Subject to Deductible and Coinsurance</td>
<td>Subject to Deductible and Coinsurance</td>
<td>Subject to Deductible and Coinsurance, then Plan Pays 100%</td>
</tr>
<tr>
<td>Emergency Room Visit Copayment</td>
<td>Subject to Deductible and Coinsurance</td>
<td>Subject to Deductible and Coinsurance</td>
<td>Subject to Deductible and Coinsurance, then Plan Pays 100%</td>
</tr>
<tr>
<td>Wellness Benefit</td>
<td>100% of In-Network Eligible Charges</td>
<td>100% of In-Network Eligible Charges</td>
<td>100% of In-Network Eligible Charges</td>
</tr>
</tbody>
</table>

**Benefit Limits**

| **Maximum Lifetime Benefit** (Unless noted) | Unlimited | Unlimited | Unlimited |
| Substance Abuse Treatment | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance |
| Mental Illness | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance |
| Chiropractic | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance |
| Hearing Aids | Up to $1,500 After the Deductible is Met Every 3 Years Per Person Covered | Up to $1,500 After the Deductible is Met Every 3 Years Per Person Covered | Up to $1,500 After the Deductible is Met Every 3 Years Per Person Covered |
| Temporomandibular Joint Dysfunction and Related Disorders | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance |
| Physical, Occupational and Speech Therapy | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance | Subject to Deductible and Coinsurance |

* * If you go to an out-of-network provider, after you meet the in-network deductible, you pay the difference between the amount the out-of-network provider charges and the out-of-network eligible expense (this is the balance billing), plus 40% of the out-of-network eligible expense (your coinsurance). The balance billing does not count toward your annual out-of-pocket maximum.*
Wellness Benefits

All three PPO plans include wellness benefits that pay 100% of in-network eligible charges for routine preventive care services for each covered person.

Wellness benefits examples include:

- Routine physical exams (no limit on visits)
- Routine diagnostic tests (lab and x-ray)
- Routine eye exams
- Routine hearing exams
- Women’s health preventive care (including birth control and breast pumps) will be reimbursed at 100% of contracted rates while using an in-network provider
- Immunizations (immunizations for foreign travel are not covered)

<table>
<thead>
<tr>
<th>Examples of Routine Preventive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Physical Exam</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
</tr>
<tr>
<td>Annual Mammogram</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
</tr>
<tr>
<td>Annual Pap Smear</td>
</tr>
</tbody>
</table>

Preventive Versus Diagnostic

**Preventive:** Services generally used to detect and (hopefully) eliminate the potential onset of a chronic health condition. Does not include screenings for individuals with specific conditions (e.g., glaucoma screening for a diabetic would not be considered preventive since the diagnosis of diabetes has been given).

**Diagnostic:** Services generally used when symptoms are present to diagnose a condition or illness.

In addition, the following services are paid at 100% when you visit a network provider:

**Periodic Preventive Tests and Services**

- Payable at 100% with no deductible and no annual maximum.
- Not subject to age or frequency limitations.

Periodic preventive services under the wellness benefit are:

- Routine sigmoidoscopy
- Routine colonoscopy
- Bone mineral density
Prescription Drug Coverage

Farm Credit Foundations prescription drug coverage is administered by CVS Caremark. The cost of your medication will vary, depending on your medical plan election and the category of medication prescribed.

Medication Categories

• **Generic Drugs**
  A generic drug is identical, or bioequivalent, to a brand name drug in dosage, safety, strength, quality, performance characteristics and intended use. You will pay the lowest copayment for generic drugs. Generics are equivalent to their brand-name counterparts, and are ensured by the Food and Drug Administration to be as safe and effective. However, generics are significantly less expensive than the brand name. To be sure you pay the lowest copayment, ask your doctor to prescribe generic medications, when appropriate.

• **Preferred Drugs**
  These are prescription drugs that have been placed on a list of preferred drugs for a medical plan. Preferred Drugs are brand name drugs that are effective for treating specific condition and are more cost-effective than equivalent non-preferred drugs. Often there is a choice of medications you can take for the same condition. One or more of these medications may be a preferred drug under this plan. They cost generally more than generics, but less than non-preferred brand name drugs.

• **Non-Preferred Brand Drugs**
  These are medications that have been patented for name and chemical content. Once the patent expires, generic drugs with a different name but the same chemical make-up typically become available. Non-preferred drugs are prescription drugs that are not generic or on the list of preferred drugs. Typically, non-preferred named drugs are the most expensive and/or have a comparable drug that is either generic or on the preferred list. Generally, these are higher-cost medications that have recently come on the market. These drugs have the highest copayment. In most cases, an alternative preferred medication is available. Depending on your personal health care needs, there may be times when non-preferred drugs are right for you. In these situations, you will need to pay the non-preferred co-payment.

• **Affordable Care Act (ACA) Preventive**
  Under the ACA there are certain drugs that are considered preventive. Examples of these medications include doctor-written prescriptions for women’s health preventive care, including Food and Drug Administration-approved contraceptive methods, preventive aspirin for men and women, iron supplements for children, folic acid for childbearing age or pregnant women, Vitamin D for at-risk adults over age 65, prescribed fluoride supplements for children under age six and tobacco cessation products. All preventive drugs and treatments require a doctor’s prescription under the preventive tier.

• **Lifestyle Drugs**
  These are prescription drugs that are not generally considered medically necessary. You will pay the full cost of the prescription after a discount has been applied. Lifestyle drugs are typically drugs that are prescribed for non-medically necessary uses such as cosmetic Botox® and Propecia® for hair loss.

• **Dispense As Written (DAW) Penalty**
  If you purchase a preferred or non-preferred drug at retail or mail when a generic is available, you will pay the brand copay plus the difference between the cost of the generic drug and the drug dispensed.
### Prescription Drug Copay Chart

<table>
<thead>
<tr>
<th>Premium PPO Plan</th>
<th>Retail (30-Day Supply)</th>
<th>Retail 90 (90-Day Supply at selected retail pharmacies)</th>
<th>Maintenance Choice (90-Day Supply at CVS pharmacies only)</th>
<th>Mail Order (90-Day Supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Copay</td>
<td>$10</td>
<td>$30</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred Brand Copay</td>
<td>$35</td>
<td>$105</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td>Non-Preferred Brand Copay</td>
<td>$60</td>
<td>$180</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Affordable Care Act (ACA)</td>
<td></td>
<td>No Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive (Prescription Required)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle Drugs*</td>
<td></td>
<td>100% of Discounted Price</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Standard PPO Plan

| Generic Copay                    | $10                     | $30                                                    | $20                                                       | $20                       |
| Preferred Brand Copay            | $35                     | $105                                                   | $90                                                       | $90                       |
| Non-Preferred Brand Copay        | $60                     | $180                                                   | $150                                                      | $150                      |
| Affordable Care Act (ACA)        |                         | No Copay                                              |                                                           |                           |
| Preventive (Prescription Required)|                         |                                                        |                                                           |                           |
| Lifestyle Drugs*                 |                         | 100% of Discounted Price                               |                                                           |                           |

### Consumer Choice PPO Plan

| Generic Copay                    | Subject to Same Deductible and Coinsurance as Other Medical Benefits |
| Preferred Brand Copay            | Subject to Same Deductible and Coinsurance as Other Medical Benefits |
| Non-Preferred Brand Copay        | Subject to Same Deductible and Coinsurance as Other Medical Benefits |
| Affordable Care Act (ACA)        | No Copay                                                             |
| Preventive (Prescription Required)|                                                        |                                                        |                           |
| Lifestyle Drugs*                 | 100% of Discounted Price                                            |                                                        |                           |
**Diabetic Supplies**

Your diabetic supply kit (swabs, lancets, syringes, and strips) is free when ordered with your insulin prescription/refill (mail order and retail). In addition, CVS Caremark has a disease management program available to help you manage your diabetes. Contact CVS Caremark for more information about this program.

**CVS Caremark’s Specialty Pharmacy**

Certain medications may need to be filled through CVS Caremark’s Specialty Pharmacy.

**Specialty pharmaceuticals** are drug therapies developed to treat a wide range of complex chronic conditions. They are generally developed to serve a relatively small population of patients, most of whom have progressively severe diseases. Patients tend to be on these medications long-term, most for life (some exceptions include RSV, infertility and Hepatitis C). These drugs may be biologically derived; many require special handling and specialized training for mixing and administration, and are often very expensive—from several thousand to hundreds of thousand per year. Specialty medications must be dispensed by CVS Caremark specialty pharmacies and cannot be obtained through regular CVS Network pharmacies.

**Specialty Guideline Management (SGM)** is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines and consensus statements. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved.

CVS Caremark Specialty Guideline Management extends beyond prior authorization ensuring:

- The specialty drug is safe and effective for the patient
- The specialty drug is used properly
- Inappropriate utilization is avoided
- Unsafe or ineffective therapies are discontinued in a timely manner
- Step therapy for TNF inhibitors and multiple sclerosis

Specialty drugs may be prescribed for the following therapies:

- Asthma
- Crohn’s disease
- Cystic fibrosis
- Growth hormone and related disorders
- Hematopoietics
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis C
- HIV
- Hormonal therapies
- Immune disorders
- Infertility
- Lysosomal storage disorders
- Macular degeneration
- Multiple sclerosis
- Oncology
- Osteoarthritis
- Osteoporosis
- Psoriasis
- Pulmonary arterial hypertension
- Pulmonary disorders
- Renal disorder
- Rheumatoid arthritis
- RSV prevention
- Transplant
Dental Plan Options

Your dental plan is a Preferred Provider Plan administered by Delta Dental of Kansas. You can choose between two plans:

- **Basic Plan**
  Provides benefits for diagnostic, preventive and basic care (including exams, cleanings, fillings and X-rays).

- **Comprehensive Plan**
  Provides all of the above, plus offers coverage for a more extensive range of dental care including orthodontia.

<table>
<thead>
<tr>
<th>Coverage Tiers</th>
<th>Basic Plan</th>
<th>Comprehensive Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$5</td>
<td>$19</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$16</td>
<td>$44</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$19</td>
<td>$52</td>
</tr>
<tr>
<td>Family</td>
<td>$29</td>
<td>$76</td>
</tr>
</tbody>
</table>

**Dental Plan Options Summary**

**Basic Plan**

- Deductible Per Person: $50/$150 Per Family
- Preventive/Diagnostic: 100% (Not Subject to Deductible)
- Basic Services: 80% (After Deductible)
- Major Services: Not Covered
- Annual Benefit Maximum*: $750 Per Person

**Comprehensive Plan**

- Deductible Per Person: $100/$300 Per Family
- Preventive/Diagnostic: 100% (Not Subject to Deductible)
- Basic Services: 80% (After Deductible)
- Major Services: 50% (After Deductible)
- Annual Benefit Maximum*: $1,500 Per Person
- Orthodontia: 50% (After Deductible)
- Orthodontia Lifetime Maximum: $2,000 Per Person

*Includes cleanings
Preventive Services
- Routine dental examinations: Twice per calendar year
- Cleaning: Twice per calendar year
- Topical fluoride application for children under age 19: Twice per calendar year
- Total mouth x-ray: Once every 36 months
- Bitewing x-rays: Twice per calendar year

Basic Services
- Restorations (fillings): Amalgam, silicate cement, acrylic and composite
- Stainless steel crowns for children under the age of 13
- Oral surgery: Extractions (uncomplicated surgical removal of an erupted tooth), incision/drainage of abscess, cyst or tumor removal
- General anesthesia and postoperative care
- Periodontics: Root planning/scaling, gingivectomy/gingivoplasty
- Endodontics: Root canals (including necessary x-rays/cultures, excluding final restoration)

Major Services
- Inlays and crowns
- Artificial teeth
- Removable bridge
- Dentures
- Implants

Network Savings
Delta Dental offers an extensive two-tier nation-wide network of providers — the Delta Dental Premier Network and the Delta Dental PPO Network. The level of eligible charges (based on network discount) will vary depending on whether you use a network provider and/or the network in which your provider participates.

Delta Dental Premier Network
- Larger network – 118,000 dentists in 163,000 offices
- Delta premier discounts
- No balance billing
- No paperwork

Delta Dental PPO Network
- Smaller network – 57,000 dentists in 88,000 offices
- Deepest discounts
- No balance billing
- No paperwork

Locate Network Providers
- Call your dentist and ask, “Do you accept Delta Dental?”
- Go to www.deltadentalks.com and search for dentists in your area.
- Call Delta Dental at 1-800-234-3375
**Example of Preventive Payment**  
*(Not Subject to Deductible)*

<table>
<thead>
<tr>
<th>Cleaning, Bitewing X-rays and Exam</th>
<th>Premier Network</th>
<th>PPO Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist’s Charge</td>
<td>$115</td>
<td>$115</td>
<td>$115</td>
</tr>
<tr>
<td>Delta’s Maximum Allowance (MPA)*</td>
<td>$108</td>
<td>$91</td>
<td>$82</td>
</tr>
<tr>
<td>Plan Pays 100% of MPA</td>
<td>$108</td>
<td>$91</td>
<td>$82</td>
</tr>
<tr>
<td>Patient Coinsurance = 0% of MPA</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Additional Amount Provider Can Charge (balance bill)</td>
<td>$0</td>
<td>$0</td>
<td>$33</td>
</tr>
<tr>
<td><strong>Total Patient Charge</strong></td>
<td><strong>$0</strong></td>
<td><strong>$0</strong></td>
<td><strong>$33</strong></td>
</tr>
</tbody>
</table>

**Example of Major Procedure**  
*(Assume Deductible Has Been Met)*

<table>
<thead>
<tr>
<th>Crown</th>
<th>Premier Network</th>
<th>PPO Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist’s Charge</td>
<td>$725</td>
<td>$725</td>
<td>$725</td>
</tr>
<tr>
<td>Delta’s Maximum Allowance (MPA)*</td>
<td>$700</td>
<td>$616</td>
<td>$525</td>
</tr>
<tr>
<td>Plan Pays 50% of MPA</td>
<td>$350</td>
<td>$308</td>
<td>$262.50</td>
</tr>
<tr>
<td>Patient Coinsurance = 50% of MPA</td>
<td>$350</td>
<td>$308</td>
<td>$262.50</td>
</tr>
<tr>
<td>Additional Amount Provider Can Charge (balance bill)</td>
<td>$0</td>
<td>$0</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Total Patient Charge</strong></td>
<td><strong>$350</strong></td>
<td><strong>$308</strong></td>
<td><strong>$462.50</strong></td>
</tr>
</tbody>
</table>

*Above charges are shown for illustration purposes only. Your experience may vary.*

Maximum Allowable Charges (MPA) for a covered procedure means the fee established by Delta Dental. Delta develops the MPA from a number of sources, including but not limited to contract with dentists, input from dental consultants, the billed charges for the same procedures by dentists in that state, and other pertinent information. The MPA for in-network procedures ranges between approximately 70-80% of retail cost. The MPA for out-of-network procedures ranges between 50-60% of retail cost. Other insurance companies or your dental provider may refer to this as “reasonable and customary” or R&C maximums. In addition, if a Delta Dental provider is used, the contract between the dentist and Delta Dental does not allow the dentist to bill you for the charges over the MPA (balance billing). However, using an out-of-network provider will put more of the cost on the participant because of the lower MPA and balance billing.
Vision Service Plan

Your Vision Plan through VSP offers coverage for you and your eligible dependents for eye exams, lenses, frames and contact lenses. VSP will also cover laser vision correction surgery at a discounted fee when you use a participating provider.

VSP pays for the majority of expenses for a number of services when you use a participating provider. Providers can be found on VSP’s website at www.vsp.com. Use the Signature Network when searching for a network provider.

When considering whether or not to elect vision coverage, consider how often you can use these benefits:

- **Exam** – Once every 12 months
- **Frames** – Once every 24 months (child(ren) once every 12 months); $180 allowance
- **Eyeglass lenses** – Once every 12 months
- **Contact lenses** – Once every 12 months; contact lens benefit is not available in the same year that frames and lenses are purchased; $180 allowance
- **Laser vision surgery** – Discounts available through network providers. Go to www.vsp.com for more information.
- **Discounts** – Available for frames, lenses and contacts if purchased in-network more often than benefit frequency. Go to www.vsp.com for more information.

**Submitting a Claim**

If a vision claim for services or materials is obtained through an out-of-network provider, you will need to pay the entire bill at the time of service and submit a claim for reimbursement to VSP. Out-of-network claims must be submitted to VSP within 12 months from the date of service.

<table>
<thead>
<tr>
<th>Vision Service Rates Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VSP Plan</strong></td>
</tr>
<tr>
<td>Employee Only</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>
Tax Advantage Accounts

Lower Your Taxable Income
You have access to various pre-tax accounts through PayFlex. With a tax advantage account, you can use tax-free money and lower your taxable income. The following accounts are designed to help you pay out-of-pocket health care and dependent care expenses on a pre-tax basis:

- Health Savings Account (HSA)
- Health Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)
- Limited Purpose Health Flexible Spending Account (FSA)

Exploring your benefit options and deciding how to maximize your health care choices and associated benefit costs are vital to your health and healthy financial future. That's why Foundations offers a selection of tax-advantage choices for you and your family.

Review the features and benefits of each account to determine which combination is right for your personal situation.

Health Savings Account (HSA)
If you enroll in the Consumer Choice High Deductible Plan, you will automatically be enrolled in a Health Savings Account. A Health Savings Account allows you to save money in a tax-free account that can grow year after year. Because these accounts have certain tax-advantages, you must meet the following IRS requirements to be eligible for an HSA:

- You participate in a qualified high deductible health plan (HDHP), such as Consumer Choice.
- You have no other medical coverage (unless it is also a qualified HDHP).
- You are not enrolled in Medicare.
- You are not claimed as a dependent on another person’s tax return.

An HSA provides a three-way tax advantage:
- You can contribute to the account on a tax-free basis. You decide when to spend or save your deposits.
- Your account earns interest income right away — tax free! When you have a minimum account balance of $1,000, you can choose to invest in a wide selection of mutual funds.
- When you withdraw your funds to pay for eligible health care expenses, the funds are typically tax free.

Health Savings Accounts are administered by PayFlex. Contributions are held in an individual account at CitiBank.

You may elect or change pre-tax contributions through payroll deduction at any time throughout the year.

The money in your HSA can be used on a tax-free basis to pay for:

- Your medical plan deductibles
- Eligible health care expenses not covered by insurance (IRS Publication 502)
- Health expenses during retirement
- Any purpose (subject to income and penalty tax if it’s not an eligible expense)
- Certain over the counter (OTC) drugs if a prescription is provided otherwise OTC drugs are excluded for reimbursement

Note: An expense may not be reimbursed from your HSA unless the expense was incurred to provide medical care for yourself, your spouse or your tax dependent (and the other conditions for reimbursing an expense must also be satisfied). This means that although you will be able to cover your 25-year-old daughter under the Consumer Choice PPO option of the Medical Plan, unpaid medical expenses for her are not HSA-eligible, unless she is your dependent for federal tax purposes.
Changing Your HSA Contribution Amount
You can change your HSA contribution amount at any time. Be sure to review your HSA contribution election amounts so you stay within the IRS regulations. Visit the IRS website for more information on HSA contribution limits at www.irs.gov (Publication 969).

HSA Maximum Annual Contribution
The annual maximum HSA contribution allowed for 2017 is $3,400 for individual (employee only) and $6,750 for family coverage (all other coverage tiers). If you are 55 or older in 2017, you can contribute an additional $1,000 “catch-up” contribution. Money not used in the account will roll forward from year to year and does not count toward the annual maximum.

Tax Form Filing
The IRS requires you to file a Form 8889 with your federal tax return if you made contributions or took withdrawals from an HSA during the tax year.

Advantages of a Health Savings Account
• **Flexibility** – Unused money rolls over from year to year.
• **Portability** – Money in your account goes with you if you retire or leave the company.
• **Value** – Account is tax-free and contributions up to the federal limit can be made each year. In addition, HSA money can be invested.

Health Care Flexible Spending Account (General Purpose)
You may contribute up to $2,600 a year to the Health Care Flexible Spending Account (FSA) if your medical plan is one of the following:

- Premium PPO Plan
- Standard PPO Plan
- Other medical coverage (i.e. HMO Plan or coverage through spouse)

At the time you enroll, you must choose from two payment options:

1. **Health Care Flexible Spending Account – Debit Card** With this payment option, you will receive a debit card which can be used to pay for eligible expenses. You can also choose to file a claim for reimbursement. In either case IRS regulations require you to provide substantiation.

2. **Health Care Flexible Spending Account – Auto Pay** With this payment option, BCBS of IL, Caremark and Delta Dental of Kansas will report to PayFlex any eligible expenses that are not covered under the plan. PayFlex will automatically reimburse you for those expenses. No further substantiation is required. If you file a claim outside of the Auto Pay process, you will be required to provide substantiation.

**Note:** You can elect either the Debit Card or Auto Pay option when you are first eligible or annually during Annual Enrollment. You cannot change your election mid-year.

Qualified expenses eligible for reimbursement with FSAs include:

- Deductibles and copayments not covered by insurance
- Prescription drugs not covered by insurance
- Eyeglasses and contact lenses
- Hearing aids
- Certain medically required supplies and equipment
- Your portion of orthodontic expenses
- Certain over-the-counter (OTC) drugs if a prescription is provided; otherwise OTC drugs are excluded for reimbursement

**Limited Purpose Health Flexible Spending Account**

If you enroll in the Consumer Choice PPO Plan with Health Savings Account, you can participate in the Limited Purpose Health Flexible Spending Account. This pre-tax feature allows you to save up to the IRS limit in your Health Savings Account while contributing up to $2,600 (pre-tax) per calendar year for non-medical reimbursable expenses such as dental or vision charges not covered under a group plan.

Qualified expenses eligible for reimbursement with a Limited Purpose Health Care FSA include:
- Dental and vision deductibles and copayments not covered by insurance
- Eyeglasses and contact lenses
- Your portion of orthodontia expenses

**Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account reimburses you for expenses associated with the care of a dependent while you and/or your spouse work or attend school. You may contribute up to $5,000 a year to this account. If you are married and file income taxes separately, your contributions to the Dependent Care Account are limited to $2,500 annually. If you are married and file income tax jointly, the total amount both you and your spouse can contribute combined to a Dependent Care account is $5,000, under IRS rules.

Your eligible dependents include:
- Your dependent children under age 13
- Your spouse who is physically or mentally unable to care for himself or herself
- Other dependents (such as elderly parents) who are physically or mentally unable to care for themselves

Eligible dependent care expenses include:
- Day care provided in a home, day care center or preschool, subject to certain legal requirements
- Adult day care facility
- Before- and after-school expenses through grade school for children under age 13
- Nanny or au pair
- Care for children when they are sick and you are at work
- Summer day camp

**Flexible Spending Accounts – Claims Substantiation Requirement**

Flexible Spending Accounts (FSAs) reimbursements require substantiation to the vendor (PayFlex) from the participant. This is an IRS requirement that vendors are required to follow. Reimbursements from FSAs must be accompanied by the appropriate documentation, typically in the form of a receipt and / or explanation of benefits (EOB). The documentation must indicate whether it is a qualified expense. In many cases, claims provided by the insurance company (BCBSIL or Delta Dental) contain the appropriate information needed. However, in some situations, account holders may need to submit additional documentation. Expenses not substantiated may result in denial of future claims, suspension of debit card or taxation of unverified transactions.

**Important Tax Information**

If you are reimbursed for an expense through your Flexible Spending Account, you cannot claim that expense as a deduction on your federal income tax return.
Accessing Your Tax-Advantage Accounts
When you enroll in the HSA, Limited Purpose Health FSA or Health FSA debit card option, you will receive a debit card. You can use your debit card for qualified expenses at most providers. You may also use your debit card to make purchases at a pharmacy using an inventory information approval system (IIAS) or one that shows 90 percent of sales come from approved FSA purchases. In all other cases, you can make your purchase with cash and file a claim for reimbursement.

MasterCard Debit Card for HSA Participants
- Save your receipts. You may have to show the IRS the expense was qualified.
- Your HSA account balance must have sufficient funds in order for you to be reimbursed for your expense. Otherwise, the transaction may not process properly or you could be charged an overdraft fee, or both.

MasterCard Debit Card for FSA Participants
- Health care claims will be substantiated at time of checkout. If approved, you will be paid up to the plan year contribution amount you have elected – even if you have not contributed those funds yet available.
- Dependent care expenses cannot be reimbursed through the debit card. Log into your account at www.PayFlex.com for payment options.

Accessing your Health FSA account with Auto Pay
If you enroll in the Health FSA auto pay option, you will be automatically reimbursed for eligible expenses that have been submitted to Blue Cross Blue Shield of Illinois, Caremark or Delta Dental of Kansas. For reimbursement of other eligible expenses, log on to your account at www.PayFlex.com for payment options.

Online Account Management
Your PayFlex Welcome Kit provides easy instructions for setting up your online account, which will provide you access to your account at any time. Online account management allows you to:

- View your account activity and balance online.
- Request an electronic check, one time or recurring bill payments, such as orthodontia.
- Update your contact information.
- Order additional debit cards (HSA and FSA).
- Provide required documentation for claim substantiation.
- Invest and save for your financial future: PayFlex offers an array of mutual funds with varying risk spectrums. You can invest in these funds once your account balance is above $1,000. Fund information is available on www.PayFlex.com (HSA only).
### Highlights of Tax-Advantage Accounts

<table>
<thead>
<tr>
<th>Tax-Advantage Accounts</th>
<th>Medical Coverage</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Savings Account (HSA)</strong></td>
<td>Consumer Choice PPO</td>
<td>• Contribute through payroll deduction. You may also make personal, after-tax contributions and file for an income tax deduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maximum 2017 contribution is $3,400 for individual and $6,750 for family; Catch-up HSA contribution for age 55 and older is $1,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use pre-tax contributions now and/or save and invest for future health care expenses. You will earn interest on your cash account and once you have $1,000 or more in your account, you can invest in mutual funds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Your HSA is portable and belongs to you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There is no &quot;use it or lose it&quot; rule; funds can grow year after year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You can also enroll in a Dependent Care FSA or Limited Purpose FSA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For a comprehensive list of eligible expenses, go to <a href="http://www.irs.gov">www.irs.gov</a> (Publication 502)</td>
</tr>
<tr>
<td><strong>Limited Purpose Flexible Spending Account (FSA)</strong></td>
<td>Consumer Choice PPO</td>
<td>• Provides pre-tax savings limited to dental and vision expenses such as orthodontia, deductibles, coinsurance, eye examinations, prescription glasses and more</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Go to <a href="http://www.irs.gov">www.irs.gov</a> to review eligible dental and vision expenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Combines with the Consumer Choice PPO and HSA programs only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $2,600 plan year maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;Use it or lose it&quot; rule applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-tax payroll deductions are automatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You can also enroll in a Dependent Care FSA</td>
</tr>
<tr>
<td><strong>Health Care Flexible Spending Account (FSA)</strong></td>
<td>Premium PPO</td>
<td>• For a comprehensive list of eligible expenses visit <a href="http://www.irs.gov">www.irs.gov</a> (Publication 502)</td>
</tr>
<tr>
<td></td>
<td>Standard PPO</td>
<td>• $2,600 plan year maximum</td>
</tr>
<tr>
<td></td>
<td>Other Coverage (i.e., HMO coverage or coverage through a spouse.)</td>
<td>• &quot;Use it or Lose it&quot; rule applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-tax payroll deductions are automatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not available to HSA participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You can also enroll in a Dependent Care FSA</td>
</tr>
<tr>
<td><strong>Dependent Care Flexible Spending Account (FSA)</strong></td>
<td>NA</td>
<td>• For a comprehensive list of eligible expenses visit <a href="http://www.irs.gov">www.irs.gov</a> (Publication 502)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $5,000 plan year maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;Use it or Lose it&quot; rule applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-tax payroll deductions are automatic</td>
</tr>
</tbody>
</table>
Life and Disability Insurance

Voluntary Accidental Death & Dismemberment Insurance

Voluntary AD&D Employee Coverage — You can purchase optional coverage for yourself in increments of $25,000 up to 10 times your total compensation, to a maximum of $750,000.

Voluntary AD&D Family Coverage — You may also choose family coverage, which includes coverage for yourself, your spouse and your dependent children. Based on your Voluntary AD&D coverage and depending on your family situation at the time of the incident, the coverage percentage for your family would be as follows:

<table>
<thead>
<tr>
<th>Family Status</th>
<th>Spouse</th>
<th>Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Only</td>
<td>60%</td>
<td>NA</td>
</tr>
<tr>
<td>Spouse and Dependents</td>
<td>50%</td>
<td>15%</td>
</tr>
<tr>
<td>Dependents Only</td>
<td>NA</td>
<td>20%</td>
</tr>
</tbody>
</table>

Cost for Voluntary AD&D Insurance

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only Coverage</td>
<td>$0.021</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>$0.032</td>
</tr>
</tbody>
</table>

Long-Term Disability (LTD) Insurance

Your employer provides you with LTD coverage equal to 66.67% of your total compensation to a maximum monthly benefit of $20,000. You automatically receive this coverage and do not need to enroll. LTD benefits begin after you have been disabled for six months (180 days). LTD benefits are offset by any disability benefits you receive from certain other sources, such as Social Security and Workers Compensation. Any benefit you receive will be increased each year you are disabled with a 3% cost-of-living adjustment (COLA).

Because long-term disability benefits are tax-free upon receipt, an after-tax deduction will be taken from your paycheck and your employer will "cancel out" your deduction with a reimbursement on the same paycheck.

Term Life Insurance and AD&D Insurance Options

Basic Employee Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Your basic life insurance coverage is a term life policy. AD&D coverage pays benefits to you or your beneficiary(ies) if you die or are injured as a result of an accident. You automatically receive life and AD&D insurance coverage of one times your total compensation. This coverage is provided by your employer at no cost to you.

Business Travel Accident Coverage

Business Travel Accident coverage pays benefits to you or your beneficiary(ies) if you die or are injured as the result of an accident while you are traveling on business. You automatically receive business travel accident coverage of three times your total compensation. This coverage is provided by your employer at no cost to you.
Optional Basic Employee Term Life and AD&D Insurance Coverage
Optional Basic Term Life & AD&D includes additional life insurance and AD&D coverage for yourself of one times your total compensation.

<table>
<thead>
<tr>
<th>Monthly Cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional Basic Employee Term Life and AD&amp;D</td>
<td>$0.135 per $1,000</td>
</tr>
</tbody>
</table>

Plan Maximums
- Maximum coverage for employer-paid Basic and employee-paid Optional Basic Employee Term Life Insurance is $1,500,000.
- Maximum coverage for employer-paid AD&D and employee-paid AD&D coverage is $1,500,000 combined per insured person.

Evidence of Insurability
If you do not enroll in Optional Basic Term Life when you become eligible, evidence of insurability is required for future participation.

How Your Life Insurance Amount is Determined
Total Compensation is equal to your current base salary plus all prior year variable pay. As a new employee, your total compensation is your current base salary.

Child Term Life Insurance
Life insurance coverage is available for eligible dependent child(ren).

<table>
<thead>
<tr>
<th>Coverage Amount</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$0.50</td>
</tr>
<tr>
<td>$10,000</td>
<td>$1.00</td>
</tr>
<tr>
<td>$15,000</td>
<td>$1.50</td>
</tr>
<tr>
<td>$20,000</td>
<td>$2.00</td>
</tr>
<tr>
<td>$25,000</td>
<td>$2.50</td>
</tr>
</tbody>
</table>
Group Universal Life Insurance (GUL) Coverage

Employee Coverage
- You have the opportunity to elect GUL coverage in multiples of one to 10 times your total compensation, to a maximum of $1,500,000.
- GUL coverage of three times your total compensation up to a maximum of $500,000 is guaranteed — no health questions or medical exam required — as long as you elect coverage within 45 days of your hire date.

Coverage for Your Spouse
- Your spouse is eligible to elect GUL coverage in increments of $25,000 up to $250,000.
- Spouse GUL coverage of up to $50,000 is guaranteed — no health questions or medical exam — as long as you elect coverage within 45 days of your hire date or within 31 days after marriage.

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly Cost</th>
<th>Age</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.030 Per $1,000</td>
<td>50-54</td>
<td>$0.132 Per $1,000</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.030 Per $1,000</td>
<td>55-59</td>
<td>$0.215 Per $1,000</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.036 Per $1,000</td>
<td>60-64</td>
<td>$0.335 Per $1,000</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.040 Per $1,000</td>
<td>65-69</td>
<td>$0.544 Per $1,000</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.060 Per $1,000</td>
<td>70-74</td>
<td>$1.327 Per $1,000</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.084 Per $1,000</td>
<td>75 over</td>
<td>$2.015 Per $1,000</td>
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</tbody>
</table>

Note: Rate is based on your age as of January 1 of each calendar year.

Cash Value Account
In addition to life insurance protection, GUL gives you the option to set aside money in a cash value account. With GUL, the money earns a fixed rate of interest and grows tax-deferred — you don’t pay taxes on any earnings unless you withdraw more than you've contributed.

Review and Update Your Beneficiaries
Minnesota Life provides a secure web site at www.LifeBenefits.com for electing, storing, and updating your life insurance beneficiary designations. This secure online service protects the privacy of your information while ensuring your beneficiary information is available when it’s needed.

Choosing a Beneficiary
Your beneficiary can be a person, a charity, a trust or your estate. You can split the benefit among multiple beneficiaries as long as the total percentage of the proceeds equal 100 percent.

- **Primary beneficiary** – The person(s) named will receive the benefit. If any named beneficiary is not living at the time of claim, the benefit will be split among any remaining primary beneficiaries before it is paid to a contingent beneficiary
- **Contingent beneficiary** – If the primary beneficiaries are no longer living, the benefit is paid to this person or persons.
- **Default beneficiary** – If you do not name a beneficiary, policy benefits will be paid to the default beneficiary listed in the certificate of insurance.
Retirement/401(k)

Your Retirement Benefits: A Defined Contribution/401(k) Plan
We offer you a dollar-for-dollar match of up to 6% of your total compensation with our 401(k) plan, which is administered by John Hancock. Your plan offers a range of investment options, including:

- Various mutual funds (public investment funds open to all investors)
- Commingled funds (typically, only available to participants in company sponsored retirement plans)
- Separately managed accounts (portfolios of securities that are managed by a registered investment manager exclusive to participants in the Farm Credit Foundations 401(k) plan)
- Self-directed brokerage feature

How to Enroll in Your Retirement Benefits
To enroll, increase or decrease your contribution, or waive participation in the plan, go to mylife.jhrps.com.

Fixed Employer Contribution
Even if you choose not to contribute any of your money, your employer will contribute an amount equal to 3% of your eligible compensation into your 401(k) account. This is called the fixed employer contribution.

Automatic Enrollment at 6%
If you do not make an election to participate in the 401(k) plan within 45 days of your hire date, you will automatically be enrolled and placed in the plan at a 6% pre-tax contribution rate. From that point on, your pre-tax contribution will increase by 1% each year on your anniversary date of hire, up to a maximum of 15%.

Defined Benefit Retirement Plans
Employees participating in one of the four Defined Benefit retirement plans do not receive the 3% fixed employer contribution, and the maximum employer match is 4%.

Contribute Pre-Tax or Roth After-Tax
You can contribute to your 401(k) plan on a pre- and Roth after-tax basis. In addition, you can designate some or all of your elective contributions as traditional after-tax Roth contributions. The minimum amount that you can contribute is 1%, and the maximum combined percentage is 75%.

Vested at 100% After 4 Years
You are vested 100% for the amount you contribute to your 401(k). For the employer contribution portion of your 401(k) account, you are vested at a rate of 25% each year of employment, and fully vested after four years.

Auto Rebalancing
If you make your own investment elections, rebalancing is the process of adjusting your investment balances to bring them back to your original asset allocation. Over time, differences in investment performance may shift your account away from your desired asset allocation strategy. A portfolio of funds that is not rebalanced periodically may become out of line with your intended allocation and risk tolerance. You can choose to have your existing account balances and future contributions automatically rebalanced every 3, 6 or 12 months.

### Foundations 401(k) Plan

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
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<tbody>
<tr>
<td>6% Your Contribution</td>
<td>+ 6% Employer Match</td>
</tr>
<tr>
<td>+ 3% Fixed Employer Contribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>= 15% Into Your 401(k) Account</td>
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</table>

www.FarmCreditFoundations.com
Take Advantage of Employer-Matching Funds!
For employees hired after Jan. 1, 2007, or for those who do not participate in their employer’s pension plan, here is an example of how you can take full advantage of the company-matching funds in the Farm Credit Foundations 401(k) plan.

Let’s say you contribute 6 percent of your eligible compensation into your 401(k) account. Now add to that amount the employer match of 6% and the fixed employer contribution of 3%, and you will have 15% added to your 401(k) account. And all you would have to contribute is 6%. Remember, no matter how much you choose to contribute on a pre-tax, Roth after-tax or traditional after-tax basis, your employer will match up to a maximum of 6% combined of your eligible compensation.

After-Tax Spillover for 401(k)
The maximum amount you can contribute into your 401(k) is $18,000 (2017), plus an additional $6,000 catch-up, if you are age 50 or over at any time during the year. If you ever reach that limit, your pre-tax and/or after-tax Roth contributions are automatically suspended and you will no longer receive the employer match. To keep receiving your employer match for the rest of the year, you can make after-tax contributions by electing the after-tax spillover feature or self-monitoring and enrolling in after-tax contributions. You will receive the maximum employer match if you continue to contribute at least 6%.

With the after-tax spillover feature, just make one election to automatically switch your contributions every year to traditional after-tax when you reach the IRS limit. Your election will continue year after year, subject to other IRS limitations, unless you make a contribution rate change.

You can enroll in the after-tax spillover by logging into your account at mylife.jhrps.com and go to View/Change from the main menu. You can also call John Hancock Retirement Plan Services at 1-800-294-3575.

Investment Help Options
• **Target Date Funds** are a “set-it-and-forget-it” option. Target Date funds choose an age-appropriate initial asset allocation and gradually get more conservative as you approach the target date. An age-appropriate Target Date fund is the default option if you do not make another investment election when joining the 401(k) plan.

• **OnTarget** is a fee-for-service “managed account” approach. With OnTarget, you turn over your saving and investment decisions to professionals from Morningstar and John Hancock who will increase your savings rate 1% every year (to a maximum of 15%) and select your funds and rebalance them quarterly. Fees range from 0.2% to 0.5% depending on your account balance.

• **Morningstar Retirement Manager** is a free investment advice feature that recommends an asset allocation and fund selection. You can use this feature periodically to rebalance your investments.

Both OnTarget and Morningstar Retirement Manager allow you to enter other assets and income, e.g. IRA's, spouse's information, which will be taken into consideration for the fund selection for you Farm Credit 401(k) account. You can learn more about any of these investment help options by accessing Investment Strategies from the main menu at mylife.jhrps.com.

Access Your Earnings Statement
You may access your Earnings Statement on Dayforce each pay period to keep track of all your year-to-date contributions. You may also view contribution postings to your 401(k) account at mylife.jhrps.com by accessing Detailed Statement Online from the main menu.
**Beneficiary Designation**
As a participant in the 401(k) plan, you are able to elect, update or change your beneficiary designation directly with John Hancock Retirement Plan Services. You have two ways to enter and update your beneficiary designation for the 401(k) plan:

**Online**
- You may access View/Change Beneficiary from the main menu at mylife.jhrps.com.

**Telephone**
- You may also provide your beneficiary election information by calling the John Hancock Participant Service Center at 1-800-294-3575. Participant Service Center Representatives are available from 9 a.m. to 10 p.m. (Eastern) on New York Stock Exchange business days.

### Plan Highlights

<table>
<thead>
<tr>
<th>Employees hired January 1, 2007 or later or do not participate in a defined benefit pension plan</th>
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<tbody>
<tr>
<td><strong>Entry Date</strong></td>
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<tr>
<td><strong>To Enroll</strong></td>
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<tr>
<td><strong>Automatic Enrollment (New Hires)</strong></td>
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<tr>
<td><strong>Fixed Employer Contribution</strong></td>
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<td><strong>Employer-Matching Contribution</strong></td>
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<td><strong>Maximum Employer Contribution</strong></td>
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<td><strong>Minimum Deferral Amount</strong></td>
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<td><strong>Maximum Deferral Amount</strong></td>
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<td><strong>Contribution Options</strong></td>
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<tr>
<td><strong>Vesting</strong></td>
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<tr>
<td><strong>Loans</strong></td>
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Farm Credit Foundations Medical Plan Notices

The notices below may be of interest to you regarding your medical coverage under the Farm Credit medical plans. These notices as well as plan descriptions are available on www.FarmCreditFoundations.com under the Resources tab. If you are unable to access these documents, please contact Farm Credit Foundations at Benefits@FarmCreditFoundations.com or by calling 1-800-892-7924.

Grandfathered Plan Notice

Although the Farm Credit Foundations Medical Plan (the “Plan”) is a governmental plan that is maintained by employers that are federally chartered instrumentalities of the United States and, as such, is not subject to many of the requirements of the Patient Protection and Affordable Care Act (“PPACA”), the Plan believes that it satisfies the requirements for a “grandfathered plan” within the meaning of Section 1251 of PPACA. Grandfathered plans are subject to a delayed effective date for certain changes that will be required by PPACA and, in some cases, are fully exempt from those requirements for as long as the plan’s grandfathered status is retained. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Farm Credit Foundations, 30 East 7th Street, Suite 3000, Saint Paul, MN 55101.

Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under your health care plan as a result of the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”). For individuals receiving mastectomy-related benefits, coverage will be provided under the plan, in a manner determined in consultation with your attending physician, for each of the following:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Post-mastectomy care for (i) inpatient treatment for the period of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and (ii) a follow-up Physician office visit or in–home nurse visit within forty-eight (48) hours after discharge.
- Treatment of physical complications of the mastectomy including, but not limited to, lymphedemas.
- Prostheses

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the plan.