TYSON FOODS, INC.
CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION
January 1, 2017

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SECTION 1 – INTRODUCTION

Tyson Foods, Inc. and designated affiliates (the “Company”) are pleased to sponsor a Cafeteria Plan for eligible employees. It is called a Cafeteria Plan because it lets you choose among several different benefit programs according to your individual needs. The Cafeteria Plan enables you to pay for the benefits you choose with pre-tax dollars and the benefits themselves are generally nontaxable. Designing your personal benefit program on a tax-favored basis is permitted under Section 125 of the Internal Revenue Code.

SECTION 2 – HOW THE CAFETERIA PLAN WORKS

Overview

Four types of benefits are available under the Cafeteria Plan. These are: (1) a health flexible spending account (the “Health FSA Choice”), (2) a dependent care flexible spending account, also known as a dependent care assistance program (the “Dependent Care Choice”), (3) Health Savings Account (“HSA") contributions, and (4) premium payments on a pre-tax basis for health plan benefits and/or voluntary accidental death and dismemberment plan benefits (the “Premiums Feature”). These four types of benefits are briefly discussed below. They are discussed in more detail later on in this Summary.

Health Flexible Spending Account

The Company’s health plan(s) do not pay for all medical, prescription, dental and vision expenses. A health flexible spending account is an account set up for you in the Cafeteria Plan (or “Health FSA Account”). The Health FSA Choice permits you to pay for your qualifying health care expenses (that are not otherwise reimbursable by insurance) with your own pre-tax dollars. You can do that by contributing pre-tax to a Health FSA Account. The Company then reimburses you periodically out of this Account for non-covered health expenses.

Dependent Care Flexible Spending Account

Many of you have children or parents who must be cared for while you are at work. You can pay for qualifying dependent care expenses by contributing on a pre-tax basis to your dependent care assistance flexible spending account (or “Dependent Care Account”). The Company will reimburse you periodically out of your Dependent Care Account for these qualifying dependent care expenses.

Health Savings Account (“HSA") Contributions

If you elect to participate in a high deductible health plan (“HDHP”) offered by the Company, you may also have the opportunity to contribute to a health savings account (“HSA") on a pre-tax basis. Your HSA is your individual account. The Company does not sponsor or maintain it. However, it does allow you to save for otherwise unreimbursed medical expenses. More details about who is eligible to contribute to an HSA and other information about contributing to an HSA are provided later in this document.

Premiums Feature

The Company provides health plan and voluntary accidental death and dismemberment plan benefits for eligible employees. Many employees are also interested in covering family

members, such as a spouse or children under the health plan or voluntary accidental death and dismemberment plan. Without the Cafeteria Plan, you would pay the employee portion of the premiums on an after-tax basis, by payroll deduction. Paying for benefits on an after-tax basis means that federal and state income taxes and FICA (Social Security and Medicare) taxes and FUTA (Federal Unemployment) taxes are withheld from your paycheck. Then, after you have paid these taxes, you would pay the premiums.

The Cafeteria Plan automatically provides for the payment of the employee portion of the premiums on a pre-tax basis for most tax purposes. This means the premium payments you make for your health plan and voluntary accidental death and dismemberment plan coverages are taken off of your W-2 income, which lowers your taxes. As a result, the Cafeteria Plan lets you pay for the benefits you want and take home more pay. However, some or all of your premiums may be withheld on an after-tax basis for state tax purposes, if state tax law requires it.

After-tax Benefits

In certain special cases, payments made on an after-tax basis are also made through the Cafeteria Plan. COBRA continuation coverage, retiree coverage, payments during a leave of absence (if applicable), and other covered benefits may be paid on an after-tax basis to the extent permitted by the plan administrator. Generally, if a benefit can be paid for on a pre-tax basis, contributions for that benefit will only be allowed on a pre-tax basis. The rules and restrictions regarding elections described in the remainder of this Summary Plan Description apply primarily to benefits paid for on a pre-tax basis. Elections for, and modification for elections of, after-tax benefits are subject to rules and restrictions as the plan administrator may adopt from time to time.

Administration

The Company administers the Cafeteria Plan and decides all questions relating to eligibility to participate and benefits. However, the Company may delegate one or more of its administrative functions under the Cafeteria Plan to one or more third party administrators that may act on behalf of the Company. Determinations relating to eligibility to participate and benefits are final and binding upon all parties. Currently, the Company pays the costs of administering the Cafeteria Plan. The Company reserves the right to amend or terminate the Cafeteria Plan or its benefits at any time.

Plan Year

The current plan year is January 1 through December 31.

About this Summary Plan Description

This Summary describes the basic features of the Cafeteria Plan, how it operates and how you can get the maximum benefits from it. This Summary is much shorter and less technical than the complete plan documents. In case of any conflict between this Summary and the plan documents - or if the Cafeteria Plan is required to operate in a different manner to comply with federal tax law - the plan document or federal laws will control.

Effect on Your Social Security Benefits

One big advantage of the Cafeteria Plan is that your pre-tax contributions reduce your income taxes. However, this also means you may pay less Social Security taxes. This could result in a slight decrease in your eventual Social Security benefits. Most employees believe the tax advantages they gain now through buying benefits on a pre-tax basis will more than offset any possible reduction in their future Social Security benefits.

SECTION 3 – WHAT BENEFITS DOES THE CAFETERIA PLAN OFFER?

The following benefits are currently available under the Cafeteria Plan:

- Health FSA Choice
- Dependent Care Choice
- HSA Contributions
- Premiums Feature

These benefits are described in more detail below. The Company can change the benefits as it sees fit.

SECTION 4 – ELIGIBILITY TO PARTICIPATE

Eligibility Conditions

Health FSA and Dependent Care Choices. You are eligible to participate in the Health FSA Choice and the Dependent Care Choice if you are a full-time employee as designated on the records of the Company. Additionally, if your position is reclassified by the Company during a calendar year so that you are no longer a full-time employee, you may continue to participate in the Health FSA Choice and/or Dependent Care Choice, as applicable, that you were participating in at the time of the reclassification. Such continued participation will only extend to the end of the calendar year in which the reclassification occurs (plus any accompanying Grace Period, as described below, that applies to the Dependent Care Choice). If you are participating in the Health FSA Choice, you will also be eligible to submit Qualifying Medical Expenses for reimbursement from any amounts carried over as described under "Full Reimbursement and Use it or Lose it Rules." However, you will not be allowed to make new contributions.

If you are considered a "highly compensated employee" within the meaning of the Internal Revenue Code, you are not eligible for participation in the Dependent Care Choice. You will be notified if this applies to you. Additionally, certain employee groups in certain locations may not be eligible to participate in the Health FSA Choice or Dependent Care Choice. You will be notified if this applies to you.

HSA Contributions. You are eligible to make HSA contributions, or have the Company make contributions to your HSA on your behalf, if you are an HSA-eligible employee and are enrolled in the Company's HDHP. Generally, to be an HSA-eligible employee, federal tax law requires that:

- You must be covered under a qualifying high-deductible health plan (HDHP), like the Company HDHP;
- You cannot be claimed as another person's tax dependent;

- You are not entitled to Medicare benefits; and
- You do not have any health coverage other than HDHP coverage except for certain types of permitted insurance or coverage as discussed in IRS Publication 969 (for example, you may participate in a health flexible spending account (FSA) or health reimbursement arrangement (HRA), but only if they are limited-purpose and/or post-deductible). If you are covered under a spouse's or domestic partner's non-HDHP plan—which can include a medical plan or general purpose health FSA—you are not eligible for an HSA.

These same requirements apply to your spouse or other family members, if enrolled in the Company HDHP. Additional details about HSAs, including rules about qualifying for an HSA, contributions to an HSA, and distributions from an HSA, can be found in IRS Publication 969 which is updated by the IRS from time to time. Additional information about making payroll deductions to an HSA through the Cafeteria Plan and about the Company contributions is available in Section 8 below.

Any amounts that were contributed to your HSA when you were not eligible may be included in your gross income and may also be subject to a 6% excise tax.

Premiums Feature. You are eligible to participate in the Premiums Feature once you meet the requirements for the applicable health plan or voluntary accidental death and dismemberment plan coverage, as applicable, offered by the Company.

Starting your Pre-Tax Contributions

Health FSA and Dependent Care Choices. You can start paying for benefits under the Health FSA Choice and/or Dependent Care Choice generally on the first day of the month following fifty-nine (59) days of continuous employment with the Company. Alternatively, you may wait until the next open enrollment period to enroll, in which case you will start paying for benefits as of the first day of the calendar year following that open enrollment period.

HSA Contributions. You can start making HSA contributions at the same time as you become eligible to make HSA contributions.

Premiums Feature. You start participating in the Premiums Feature at the same time you enter the applicable health plan or voluntary accidental death and dismemberment plan.

Enrolling in the Plan

Health FSA and Dependent Care Choices. Your decision to pay for your benefits pre-tax under the Health FSA Choice and/or the Dependent Care Choice is completely voluntary. It is up to you to choose the level of benefits you want for you (and your family, if appropriate, subject to limits described below). Any decision to contribute to the Health FSA Choice and/or Dependent Care Choice must be made annually during each open enrollment period if you want to continue to contribute to the Health FSA Choice and/or Dependent Care Choice in subsequent calendar years.

HSA Contributions. Your decision to contribute to an HSA is completely voluntary. It is up to you to choose the level of contributions you want to make (subject to the limits described below). You can change your level of contributions at any time and the change will become effective as of the next payroll period after it is processed by the Plan Administrator. Your HSA contribution

election will continue until changed by you. However, contributions will stop if you are no longer enrolled in the HDHP.

Premiums Feature. Your enrollment in the Premiums Feature is automatic if you are enrolled in the health plan or voluntary accidental death and dismemberment plan. You may only elect to cover your spouse and dependents in the health plan or accidental death and dismemberment plan if you are already covered under the health plan or become covered simultaneously with them. Your enrollment in the Premiums Feature will continue from year to year unless changed by you during open enrollment or in connection with a change in status event described below.

For all purposes under the Plan, your spouse is an individual whose marriage to you is (a) evidenced by a license issued by an appropriate governmental authority of the jurisdiction in which your marriage took place; or (b) recognized as a common law marriage by the laws of the state where you reside, but only if the marriage is also evidenced with filing by the couple of the most recently due Federal Income Tax return under the status of "married filing jointly" or "married filing separately" or such other evidence acceptable to the Plan Administrator.

Termination of Participation in the Plan

You will cease to participate in the Cafeteria Plan if any of the following events occurs, whichever one happens first:

- To the extent you participate in the Health FSA Choice or Dependent Care Choice, you reach the end of the calendar year (plus any applicable Grace Period for the Dependent Care Choice as described below), unless under the Health FSA Choice you have amounts carried over to the next calendar year, as described below, in which case your participation will end when your Health FSA Choice account is exhausted,
- You terminate employment with the Company and you do not elect "Continuation Coverage" as described in Section 11,
- You stop contributing,
- You cease to meet the Cafeteria Plan's eligibility requirements, or
- The Company terminates the Cafeteria Plan.

Paid Leave of Absence

You will continue to participate in the Premiums Feature for the health plan and Health FSA Choice during a paid leave of absence. This is a leave of absence during which you continue to receive compensation in the form of salary, wages, bonuses or vacation pay, sick pay and the like. These items of compensation will allow you to continue contributing to the Cafeteria Plan by pre-tax payroll deduction for these benefits while on paid leave.

You will not continue to participate in the Dependent Care Choice during a paid leave. This is because dependent care expenses incurred during a leave of absence are generally not reimbursable from the Dependent Care Choice under federal tax law. If you return from leave in the same calendar year, the maximum amount you elected for reimbursement under the Dependent Care Choice will be reduced by the amount of contributions you did not make during the period of leave.

Additionally, payroll deduction HSA contributions will not continue during a paid leave. However, you may contribute to your HSA outside the cafeteria plan.

Whether you continue to participate in the Premiums Feature for the voluntary accidental death and dismemberment coverage will depend on the terms of the applicable plan documents and the Company's leave of absence policy.

Unpaid Leave of Absence

If you experience an unpaid, but approved, leave of absence, whether or not it is authorized under the Family and Medical Leave Act ("FMLA"), your Premiums Feature for the health plan will continue automatically if you continue with your health plan benefits. In addition, your Health FSA Choice benefits will automatically continue during the period of your leave. You may be required to pay the premiums for the period of the leave with after-tax dollars while on leave or in another manner that is available under federal tax law that the plan administrator may, in its discretion, permit. If you do not make all required contributions for your Premiums Feature, your coverage under the health plan may be cancelled. However, if the Company continues your coverage under the Premiums Feature and you return to work in the same calendar year, your payroll deductions for the balance of the year may be adjusted to make up the missed contributions. If you do not make all required contributions for your Health FSA Choice benefits and you return to work in the same calendar year, your payroll deductions for the balance of the year will be adjusted to make up the missed contributions. If you do not make all required contributions for your Health FSA Choice benefits and you do not return to work in the same calendar year, you may be required to make up the missed contributions with after-tax dollars after the calendar year has ended. Qualifying medical expenses incurred during the period of the leave will be reimbursable from the Health FSA Choice in accordance with the Company's administrative procedures.

However, you will not continue to participate in the Dependent Care Choice during an unpaid leave. This is because dependent care expenses incurred during a leave of absence are generally not reimbursable from the Dependent Care Choice under federal tax law. If you return from leave in the same calendar year, the maximum amount you elected for reimbursement under the Dependent Care Choice will be reduced by the amount of contributions you did not make during the period of leave.

Additionally, payroll deduction HSA contributions will not continue during an unpaid leave. However, you may contribute to your HSA outside the cafeteria plan.

Whether you continue to participate in the Premiums Feature for the voluntary accidental death and dismemberment coverage will depend on the terms of the applicable plan documents and the Company's leave of absence policy.

Termination of Employment

If you terminate your employment during the calendar year, your active participation in the Cafeteria Plan and its benefits will cease, and you will not be able to make any more contributions to the Cafeteria Plan, subject to any COBRA rights as described in Section 11 below. If you terminate your employment, return to work with the Company within the same calendar year, and your return to work is within thirty (30) days of your termination or is otherwise treated as a reinstatement, then your elections will be the same as what they were prior to your termination of employment (that is, your prior elections will be continued or reinstated). If you terminate your employment, return to work with the Company in a different calendar year, and your return to work is treated as a reinstatement, then you will be eligible to make new elections for the Health FSA Choice, Dependent Care Choice, and Premiums Feature

(your prior elections will NOT be continued or reinstated). If you terminate your employment, return to work with the Company, and your return to work is treated as a rehiring, you will be eligible to make new elections for the Health FSA Choice, Dependent Care Choice, and Premiums Feature once you have met the applicable eligibility conditions for each benefit (see "**Starting your Pre-Tax Contributions**" above).

SECTION 5 – CHANGING YOUR ELECTIONS DURING THE CALENDAR YEAR

As a general rule, you may not change your benefit elections under the Cafeteria Plan during the calendar year, although your elections will terminate if you are no longer working for the Company. Otherwise, as a general rule, you may change your elections only during the annual open enrollment period before the beginning of each new calendar year.

However, there are several important exceptions to that rule. One exception to that rule relates to a designated level of dental coverage under the health plan that requires you to maintain coverage for a continuous period of two (2) years. If you enroll in that level of coverage, then you may not change your election during an annual enrollment period for coverage any year that is part of that two (2) continuous year period, except as expressly permitted by the Cafeteria Plan.

Additionally, you may change your level of HSA contributions at any time. Your change will be effective as of the payroll period following when it is processed by the plan administrator.

To the extent permitted by your benefit package option, you may change or revoke your previous elections during a calendar year if you file a written request for change with your Company within two (2) months for any of the following special circumstances:

1. Change in Status. If you or your family has one or more of the following Changes in Status, you may generally revoke your old election and make a new election, provided that both the revocation and new election are caused by and are consistent with the Change in Status (as described below). This means the Change in Status event must result in you, your spouse or your dependent becoming eligible or ineligible for a benefit (or a particular benefit option) under this Cafeteria Plan (or your spouse's or dependent's plan) and the election change corresponds with the gain or loss of coverage.

- A change in your legal marital status (such as your marriage, your divorce or the death of your spouse).

- A change in the number of your dependents (such as birth or adoption of a child, or death of a dependent).

- Any of the following events that change the employment status of you, your spouse or your dependent, if that event affects eligibility for benefits under this Cafeteria Plan or any other cafeteria plan or employee benefit plan for you, your spouse or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment; commencement of or return from an unpaid leave of absence, but only if such leave of absence results in a loss of coverage; switching from salaried to hourly-paid, from union to non-union or from full-time to part-time (or vice versa); a reduction or increase in hours of employment; or any other similar change resulting in the person becoming (or ceasing to become) eligible for a particular employee benefit.

- Your dependent satisfying or ceasing to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age).

2. Change in Status - Other Requirements. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. Election changes may not be made to commence, increase or reduce benefits under the Health FSA Choice during a calendar year; however, election changes may be made to cancel benefits under the Health FSA Choice completely due to the occurrence of any of the following events: death of your spouse, divorce, or annulment; death of your dependent; change in employment status such that you become ineligible for the Health FSA Choice; or your dependent's ceasing to satisfy eligibility requirements for the Health FSA Choice on account of attaining a certain age, etc. However, you cannot cancel your Health FSA Choice election if you have already been reimbursed for more than you have contributed to the account. Election changes may not be made to commence Dependent Care Choice benefits during a calendar year regardless of the nature of the Change in Status. If you are otherwise eligible to make an election change, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For the Premiums Feature, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce or annulment from your spouse, the death of your spouse or your dependent, or your dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the health plan benefits for the affected spouse or dependent. However, if you, your spouse or dependent elect COBRA continuation coverage for any reason and you remain a participant under this Cafeteria Plan, you may be able to increase your contribution to pay for such COBRA continuation coverage.

Gain of Coverage Eligibility under another Employer's Plan. For a Change in Status in which you, your spouse or your dependent gains eligibility for coverage under another employer's cafeteria plan (or a benefit covered under the other employer's cafeteria plan) as a result of a change in your marital status or a change in your spouse's or your dependent's employment status, your election to cease or, if applicable, decrease coverage for that individual under this Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

Dependent Care Choice. With respect to the Dependent Care Choice, you may terminate your election or may change your election to increase or decrease Dependent Care Choice benefits with respect to a Change in Status event only if (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for Dependent Care Choice benefits; or (2) your election change is on account of a Change in Status that affects the eligibility of dependent care expenses for the available tax exclusion. For example, suppose you are reducing your salary to pay for dependent care expenses for your 12-year old daughter. In the middle of the calendar year your daughter turns 13 years old and is no longer eligible to participate in the Dependent Care Choice. This event constitutes a Change in Status which allows you to cancel coverage under the Dependent Care Choice.

3. Special HIPAA Enrollment Rights. (This applies to the Premiums Feature for health plan benefits only.) HIPAA, a federal health law, may give you or your family special

enrollment rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in the health plan for yourself or your eligible dependents because of outside medical coverage, but eligibility for such coverage is subsequently lost due to certain reasons (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, expiration of COBRA coverage, or loss of coverage under Medicaid or a State-sponsored child health plan under the federal Social Security Act), you may be able to elect health plan coverage under the Premiums Feature for yourself and your eligible dependents who lost such coverage, provided you request enrollment within two (2) months after the applicable event. In addition, if you declined coverage for a calendar year for yourself or your eligible dependents and during that year you become eligible for health plan premium assistance from Medicaid or a State-sponsored child health plan under the federal Social Security Act, you may be able to elect health plan coverage under the Premiums Feature for yourself and your eligible dependents who became eligible for such assistance, provided you request enrollment within two (2) months after becoming eligible for such assistance.

Also, if you have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your newly acquired dependents, provided you request enrollment within two (2) months after the birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, you may be able to enroll yourself, your spouse, and your newly acquired dependents, provided you request enrollment within two (2) months after the marriage. Please refer to the applicable health plan description for an explanation of these special enrollment rights.

4. Certain Judgments and Orders. (This applies to the Premiums Feature and to the Health FSA Choice.) If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child to be covered under the Cafeteria Plan, you may change your election to provide coverage for the child. If the order requires that your former spouse cover the dependent child, you may change your election to revoke coverage for the child.

5. Entitlement to Medicare or Medicaid. (This applies to the Premiums Feature for the health plan only.) If you are or become enrolled in Medicare Parts A and B, you may elect to waive or terminate coverage. If your spouse or a dependent becomes entitled to Medicare or Medicaid, you may change coverage under the health plan, but cannot terminate coverage altogether. Similarly, if you were entitled to Medicare or Medicaid and lose eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin coverage. If your spouse or a dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to change coverage, but cannot begin coverage for your spouse or dependent unless you are already covered or can elect to become covered at the same time.

6. Significant Changes in Cost. (This applies to the Premiums Feature and Dependent Care Choice but not to the Health FSA Choice.) If you are notified that the cost of your coverage will significantly increase during the calendar year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another option that provides similar coverage or elect similar coverage under the cafeteria plan of your spouse's employer; or (c) drop your coverage if there is no other option available that provides similar coverage. A health flexible spending account is not similar coverage with respect to a health plan that is not a health flexible spending account.

An HMO and a PPO are considered to be similar coverage. Coverage under the cafeteria plan of your spouse's employer or dependent's employer is treated as similar coverage.

7. Change in Coverage. (This applies to the Premiums Feature and Dependent Care Choice but not to the Health FSA Choice.) You may change your election for the Cafeteria Plan if one of the following occurs:

- *Significant curtailment of coverage.* If your coverage under the Cafeteria Plan is significantly curtailed without a loss of coverage (for example, an increase in the deductible), you may revoke your election and elect coverage under another option that provides similar coverage. If your coverage under the Cafeteria Plan is significantly curtailed with a loss of coverage, then you may either revoke your election and elect coverage under another option that provides similar coverage, or elect similar coverage under the cafeteria plan of your spouse's employer, or drop coverage but only if there is no option available under the cafeteria plan of your spouse's employer that provides a similar coverage.

- *Addition or significant improvement of a Plan option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, a participant who is enrolled in an option other than the new or improved option may elect the new or improved option. The new or improved option may be elected on a prospective basis subject to limitations imposed by the health plan or voluntary accidental death or dismemberment plan, as applicable.

- *Change in election under another employer's plan.* If an election is made by your spouse to drop coverage during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

- *Dependent Care Choice coverage changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, you may change coverage to reflect the cost of the new service provider; or (b) if you terminate a dependent care service provider because a relative becomes available to take care of your child or parent at no charge, you may cancel coverage.

8. Change in Expected Hours and Enrollment in Other Coverage. (This only applies to the Premiums Feature.) If you were reasonably expected to average at least 30 hours of service per week for a calendar year, but due to a change in your employment status, you instead are reasonably expected to average less than 30 hours of service per week, then you may revoke your election under the Premiums Feature for yourself and, if applicable, your spouse and dependents if you intend to enroll in another plan. The other plan must be considered "minimum essential coverage" for purposes of the Affordable Care Act. To be able to change your election, your coverage under the other plan must be effective no later than the first day of the second month following the month in which you make your election change. You will have to sign a form stating that you intend to enroll in the other plan, that the other plan provides minimum essential coverage, and the effective date of your coverage under the other plan.

9. Exchange Special Enrollment Period. (This only applies to the Premiums Feature.) You may revoke your election for yourself, your spouse, and your dependents if you

become eligible for a special enrollment period to enroll in a qualified health plan through a marketplace established under the Affordable Care Act, or if you want to enroll in a marketplace plan during the marketplace's annual open enrollment period. You must intend to enroll yourself and your spouse and dependents, if applicable, in the marketplace plan. Your coverage under the marketplace plan must be effective no later than the day immediately following the last day of coverage under the health plan. You will have to sign a form stating that you are eligible for the marketplace enrollment opportunity that you have enrolled, or intend to enroll, in a marketplace plan, and the effective date of coverage.

10. FMLA Leave. You may change an election under the Cafeteria Plan upon FMLA leave, as described in Section 4.

11. Special Rules for Mandatory Two (2) Year Dental Election. If you enroll in a designated level of dental coverage under the health plan that requires you to maintain coverage for a continuous period of two (2) years, then your ability to change your election for such coverage under paragraphs 1 through 10 above will be limited during that two (2) continuous year period. Specifically, if you have an event that would otherwise permit you to change your election under paragraphs 1 through 10 above, you may only change your election related to that level of dental coverage during that two (2) continuous year period to do one of the following:

- Add a dependent or remove a dependent from that level of dental coverage.
- Eliminate such coverage, but only if you elect to cease all coverage under the health plan.

After you have been enrolled in the designated dental coverage for two (2) continuous years, you will be able to make changes in your elections at annual enrollment or pursuant to paragraphs 1 through 10 above.

You may also elect to enroll yourself and your dependents in the designated level of dental coverage if you would be allowed to do so based on a change in status under paragraphs 1 through 10. If you do so, your two (2) continuous year period will be measured from the date you enroll in that coverage.

12. Special Rule for Premiums Feature. Generally, you may not switch between a PPO option and an HDHP option under the health plan for a plan year, even if you have a change in status. However, you may switch if you have a HIPAA special enrollment right (described above).

13. Prevention of Discrimination. To prevent the Cafeteria Plan from becoming discriminatory under the Internal Revenue Code, the Company may modify your election(s) downward during the calendar year if you are a key employee or highly compensated individual (as defined under the Internal Revenue Code).

SECTION 6 – HEALTH FSA CHOICE

Unreimbursed Medical, Drug, Dental and Vision Expenses

There are some qualifying medical, drug, vision and dental expenses that are not covered by the Company's health plan. You may also have deductibles and copays. Normally, you would pay

for those expenses with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn more than $100 to pay for $100 of non-covered medical expenses.

To help this situation, your Company offers the Health FSA Choice. The Health FSA Choice allows you to contribute pre-tax income to your Health FSA Account in order to reimburse yourself for qualifying medical, drug, dental or vision expenses you have paid because the health plan does not cover them. The money you contribute to your Health FSA Account by automatic payroll deduction is not subject to federal or Social Security taxes.

Limited Purpose Health FSA Account

If you, your spouse, or your dependents will be contributing to an HSA formed under Section 223 of the Internal Revenue Code, or are receiving contributions in an HSA from the Company, another employer, or anyone else, and you want to receive medical reimbursements under a Health FSA Account established under this Plan, you may only participate in a Limited Purpose Health FSA Account under which only expenses related to vision and dental services are eligible for reimbursement. This applies whether you are enrolled in the Company HDHP and contributing to an HSA through this plan or otherwise. You must notify the plan administrator that you will be contributing to an HSA.

How You Can Set Up Your Health FSA Account

If you wish to sign up for the Health FSA Choice, you must timely elect to contribute according to the Company's enrollment process before you can receive reimbursement for each calendar year that you elect to contribute. The Company or its recordkeeper will keep track of your contributions to your Health FSA Account and the reimbursements you receive from your Account.

How Much Should You Contribute?

You should estimate the amount of medical, drug, dental and vision expenses you (and your family if appropriate) are likely to incur during the calendar year which will not be reimbursed by the health plan. If possible, you should look at the amount of expenses the health plan has not covered over the past couple of years, and then think about your and your family's likely health expenses for the coming year. This will require a careful budgeting decision by you (and your family). The maximum amount you can contribute during each calendar year to your Health FSA Account is subject to the maximum amount allowed by IRS rules and the minimum amount is $500. However, if you have an amount carried over from a prior year (as described below under "Full Reimbursement and Use-it or Lose-it Rules"), you will be able to use that amount even if you do not elect the minimum $500. The maximum amount is set by law and may be adjusted in future years by the IRS to reflect changes in the cost of living. The maximum amount that you may elect for a calendar year is determined and communicated by the Company each year.

Qualifying Medical Expenses

The Health FSA Choice (like the health plan) only covers qualifying medical expenses. These are medical expenses incurred by you, your spouse or an eligible dependent for which you have not been reimbursed from insurance or some other source and for which you could claim a medical expense deduction on an itemized federal income tax return. Insurance premiums for you or your spouse, expenses for long-term care services and expenses for certain cosmetic or elective surgery are examples of just some of the expenses that are not eligible medical

expenses. In addition, over-the-counter drugs are not eligible for reimbursement unless they are prescribed by your doctor. IRS Publication 502, “Medical and Dental Expenses,” lists eligible medical expenses.

Each dependent for whom you incur medical expenses must be:

- your child, your stepchild, or foster child who is under age 27 and will not turn age 27 before the end of the applicable calendar year;

- your sibling (or any descendant of your child, foster child, or sibling) under age 19 by the end of the year (or age 24, if a full-time student) who lives with you for more than one-half of the year and who has not provided over one-half of his or her own support for the year; or

- certain relatives, including parents, siblings and children older than the normal ages to qualify as a dependent child, who live with you for more than one-half of the year and for whom you provide more than one-half of their support.

Full Reimbursement and Use It or Lose It Rules

The full amount of your annual contributions to your Health FSA Account (plus any amount carried over from the prior calendar year) is available to reimburse you for eligible medical expenses (not covered by the health plan) at any time during the calendar year. Reimbursement during the calendar year is available as long as you continue to pay premiums, to the extent elected. For example, suppose you elected to contribute $100 per month to your Health FSA Account for the calendar year and had no amounts carried over from the prior year. This means you can be reimbursed out of your Health FSA Account for as much as $1,200 any time during the calendar year (reduced by the amount of prior reimbursements received during the year) even if you have not yet contributed $1,200 to your Account.

Carryover Feature. The Health FSA provides a carryover feature allowed by IRS rules. The IRS allows up to $500 of unused amounts from a prior calendar year to be carried over to the next calendar year, as long as you are still eligible for the Health FSA Choice in that next year (including if you are only eligible to submit Qualifying Medical Expenses for reimbursement). For example, if you elect $1,200 in contributions a calendar year, but only receive reimbursement of $700 in that calendar year, the remaining $500 can be used to reimburse expenses you have in the following calendar year. Even with this feature, you can still elect the full amount for a calendar year. For example, if you have a $500 carryover amount from a calendar year and elect the IRS maximum amount for the following calendar year, you can be reimbursed for up to the IRS maximum amount plus the $500 carryover amount in unreimbursed medical expenses. Therefore, it is important for you to consider the amount of any unused contributions to a Health FSA Account for a current calendar year when deciding during open enrollment how much to contribute to a Health FSA Account for the next calendar year.

The amount you will carry over will be determined after the deadline for submitting expenses for the prior year, as described below. After the deadline for submitting expenses for the prior year is over, expenses incurred in a given year will be reimbursed from the carryover amount if any, before they are reimbursed from contributions made during the current calendar year.

If you have more than $500 left over at the end of a calendar year, then only $500 can be carried over to the next year. For example, if you have $650 left in your Health FSA Account at the end

of the calendar year, $500 will be carried over to the next year and $150 will be forfeited. This is another example of the “use it or lose it” rule. As you can see, your Health FSA Account can be very helpful, but there is a risk that you could lose some or all of your contributions if you overestimate your medical expenses.

When Reimbursable Expenses Must be Incurred

Eligible medical expenses must be incurred during the calendar year. You will not be reimbursed for any medical expenses after you are no longer a participant in the Cafeteria Plan. A medical expense is incurred when the service is provided, not when the expense was paid. Note that if you paid for a medical expense but the services have not yet been rendered, then the expense has not been incurred for purposes of your Health FSA Account. However, you may continue to submit claims up to March 31 after the calendar year ends for expenses incurred during the prior calendar year.

Reimbursement Procedures

Automatic Reimbursement. If your medical expenses (other than expenses for vision and eligible over-the-counter drug benefits) may be covered by the health plan, the Company or its recordkeeper generally will process any unreimbursed expenses under your Health FSA Account automatically without the need of your filing a separate reimbursement claim. You must take steps with the Health FSA claims administrator to opt-out of this feature. If you have a Health FSA Account and also participate in a health reimbursement arrangement (HRA) offered by the Company, expenses will first be paid from the Health FSA Account. You may not be reimbursed from both the Health FSA Account and the HRA for the same expense. If you also have money in an HSA, you may not seek reimbursement from the HSA for an expense that was reimbursed from the Health FSA Account or the HRA.

Submission of Claims. If the medical expenses are not covered by any other source, you must provide written statements or bills from independent third parties stating that the medical expense has been incurred and the amount of such medical expense. Generally, this requires including an “EOB” statement from the other health plan (or a bill from a doctor’s office) indicating the amounts that you are obligated to pay.

If the medical expenses are not covered by another source and involve a medicine or drug, you must provide the original third party receipt which indicates the name of the medicine or drug, the date purchased, and the amount paid. You should circle on the receipt the items being requested for reimbursement. For over-the-counter drugs, a written prescription from a medical practitioner is required.

To file a claim, complete a Health Care Account Claim form which you may obtain from the Company or submit your claim electronically through the third party claims administrator’s website. Your failure to comply with these reimbursement procedures may delay the reimbursement. If you have any questions or need additional information, you should contact the recordkeeper named on the form.

Eligible medical expenses will generally be reimbursed from your Health FSA Account on a weekly basis. Claims for small amounts will be held and added together until they equal or exceed $5 before they are processed.

Please note that it is not necessary for you to have paid for an eligible medical expense in order to request reimbursement from your Health FSA Account. It is only necessary that you have incurred the expense, and that the expense is not being paid for or reimbursed from any other source.

SECTION 7 – DEPENDENT CARE CHOICE

Overview

The Cafeteria Plan permits you to contribute to a Dependent Care Account out of your paychecks on a pre-tax basis to reimburse you for your child care and elder care expenses. Basically, these are expenses you pay for a babysitter, nurse at home, or qualified day care center to enable you to work outside your home.

How You Can Set Up Your Dependent Care Account

If you wish to sign up for a Dependent Care Account, you must timely elect to contribute according to the Company's enrollment process before you can receive reimbursement for each calendar year that you elect to contribute. Thereafter, that Account will be credited with your pre-tax contributions by payroll deduction. The amount you elect to contribute to your Dependent Care Account should not exceed your anticipated dependent care expenses for the year.

For example, suppose you have elected to contribute $2,600 to your Dependent Care Account for the calendar year (because you estimate at least that amount of eligible dependent care expenses). By year-end, your Account would be credited (and funded) with a total of $2,600 out of your paychecks. You will be reimbursed for your eligible dependent care expenses up to the amount you have contributed to your Account, less any reimbursements already paid. The Company or its recordkeeper will keep track of your contributions to your Dependent Care Account and the reimbursements you have received from your Account.

What is the Maximum Dependent Care Expense Reimbursement Amount I May Elect?

This amount is limited by Section 129 of the Internal Revenue Code. The maximum amount is currently $5,000 per calendar year if:

- You are married and file a joint tax return;
- You meet the following tests: you are married but your spouse maintains a separate residence for the last six months of the calendar year and you file a separate tax return; and you furnish more than one-half the cost of maintaining the dependents for whom you are eligible to receive tax-free reimbursements from your Dependent Care Account; or
- You are single, or a head of household for tax purposes.

If you are married and reside with your spouse but file a separate federal income tax return, the maximum dependent care reimbursement you may elect for a calendar year is $2,500.

However, the actual amount you can be reimbursed is also limited by the definition of dependent care expenses, which is explained below.

Definition of "Dependent Care Expenses"

"Dependent care expenses" means employment-related expenses incurred on behalf of any dependent who meets the requirements to be a Qualifying Individual, as defined in paragraph (a) below. All of the following conditions must be met for such expenses to qualify as dependent care expenses that are eligible for reimbursement.

(a) Each dependent for whom you incur the expenses must be a Qualifying Individual - that is, he or she must be:

- your child, foster child or sibling (or any descendants of any such individual) under age 13 who lives with you for more than one-half of the year and who has not provided over one-half of his or her own support for the year;

- your child, foster child or sibling (or any descendant of such individual) who has not reached age 19 (or 24, if the individual is a full-time student), but only if such person is physically or mentally incapable of self-care, he or she lives with you for more than one-half of the year and he or she has not provided over one-half of his or her own support for the year;

- your child or foster child who is over 19 (or 24, if the individual is a full-time student) or your spouse, your sibling, (any descendant of such individual) of any age, but only if such child, spouse or other person is physically or mentally incapable of self-care, he or she lives with you for more than one-half of the year and he or she receives over one-half of his or her support from you; or

- certain relatives, including parents (and their ancestors), stepparents and in-laws, but only if he or she is physically or mentally incapable of self-care, he or she lives with you for more than one-half of the year and he or she receives over one-half of his or her support from you.

(b) No reimbursement will be made to the extent that such reimbursement would exceed the balance in your Dependent Care Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the calendar year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts.

- your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);

- the earned income of your spouse for the calendar year (your spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals), for each month in which your spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student); or

- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described above.

(c) The expenses are incurred for services rendered after the date of your election to receive Dependent Care Choice benefits and during the calendar year (and Grace Period, if applicable) to which the election applies.

(d) The expenses are incurred to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.

(e) The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.

(f) If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your dependent child under federal tax law; or (2) your spouse or a person who is your dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.

(g) If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

(h) The person who provided care was not your spouse or a person for whom you are entitled to a personal exemption under Section 151(c) of the Internal Revenue Code. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.

(i) The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

For more information about what items are - and are not - deductible dependent care expenses, consult IRS Publication 503 (Child and Dependent Care Expenses), under the heading “Tests to Claim the Credit.”

Dependent Care Reimbursement Procedures

If you have elected to contribute to your Dependent Care Account, you must complete a Dependent Care Account Claim form which you may obtain from the Company or submit your claim electronically through the third party claims administrator’s website. Your failure to comply with the reimbursement procedures may delay your reimbursement. If you have any questions or need additional information, you should contact the Company or the recordkeeper.

If you have enough money in your Dependent Care Account, you will be reimbursed for your eligible expenses on a weekly basis. Claims for small amounts will be held and added together until they equal or exceed $5 before they are processed.

If your claim exceeds the funds in your Dependent Care Account, the excess part of your claim will be carried over into following months, to be paid out as your Account balance becomes

adequate. However, you may never be reimbursed for any total dependent care expenses above your annualized contributions to your Account.

When Reimbursable Expenses Must be Incurred

Dependent care expenses must have been incurred during the calendar year or the Grace Period (as described below). You will not be reimbursed for any dependent care expense after you are no longer a participant in the Cafeteria Plan. A dependent care expense is incurred when the service that gives rise to the expense is provided, not when it is paid for. If you have prepaid the expense but the services have not yet been rendered, then the expense had not been incurred for purposes of your Dependent Care Account. For example, if you pay for your child's daycare on the first day of the month for care to be given during the entire month, the expense has not been incurred until the end of the month. You will not be reimbursed for any expenses arising before your Dependent Care Choice effective date, for any expenses incurred after the close of the Grace Period, or after you have terminated employment if you terminate employment before the end of the calendar year. Nevertheless, you may continue to submit claims up to April 30 after the calendar year ends for the prior year's expenses.

Use it or Lose It Rule

The rules of the Internal Revenue Code and the reimbursement rules for the Cafeteria Plan provide a Grace Period of up to two and one-half (2 ½) months following the end of the calendar year (i.e., March 15th) for incurring claims with respect to a Dependent Care Account. The Grace Period is available to those Participants whose participation continues to be in effect at the end of the calendar year. Eligible expenses incurred while a Participant during Grace Period will be reimbursed from any contributions remaining in the Dependent Care Account at the end of the preceding calendar year before they are reimbursed from contributions made during the current calendar year, if any. For example, say you have $200 left in your Dependent Care Account from the prior year and have made $100 in contributions to a Dependent Care Account for the current calendar year. If you incur a dependent care expense of $250 during the Grace Period, the first $200 of reimbursements will come from the prior year contributions and the remaining $50 will come from the current year contributions. Therefore, it is important for you to consider the amount of any unused contributions to a Dependent Care Account for a current calendar year when deciding during open enrollment how much to contribute to a Dependent Care Account for the next calendar year.

Any contributions for a calendar year which remain unused at the end of the applicable Grace Period will be forfeited. So suppose you incur only $1,000 of dependent care expenses during a calendar year, but contributed $1,200 during that calendar year. You will be able to use the remaining $200 during the Grace Period. However, you must forfeit the other $200 if it remains unused at the end of the Grace Period. As you can see, your Dependent Care Account can be very helpful, but there is a risk that you could lose some or all of your contributions if you overestimate your dependent care expenses.

Tax Treatment on Your Dependent Care Reimbursements

You will not normally be taxed on your dependent care reimbursements. However, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040). You must list on Form 2441 the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free dependent care reimbursement.

Claiming the Dependent Care Credit on Your Tax Return

Under some circumstances, you may be able to contribute to your Dependent Care Account and still be eligible for the dependent care services tax credit under Section 21 of the Internal Revenue Code. (For example, if you contribute $3,000 to your Dependent Care Account and are reimbursed $3,000, but you had dependent care expenses totaling $5,000, you may count the excess $2,000 when calculating the dependent care credit. However, the amount of any dependent care credit you may have will be offset by any Dependent Care reimbursements received under the Cafeteria Plan.)

Explanation of the Household and Dependent Care Tax Credit

The household and dependent care credit is an allowance under the Internal Revenue Code for a percentage of your annual, eligible employment-related expenses as a credit against your federal income tax liability. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents), to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your and your spouse's adjusted gross incomes over $15,000.

> **Illustration:** Assume you have one dependent for whom you have incurred eligible expenses of $3,600, and that your adjusted gross income is $21,000. Since only one dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% - ($21,000 - $15,000)/$2,000 x 1% = 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more dependents, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Comparing Dependent Care Reimbursements to the Dependent Care Credit

Generally, the lower your income tax bracket, the more likely you are to come out ahead by claiming the dependent care credit for your dependent care expenses. That would mean you would not elect to contribute to a Dependent Care Account. On the other hand, you would generally be better off to contribute to your Dependent Care Account if your tax bracket is higher. Determining which method is better (that is, reimbursements from your Dependent Care Account or claiming the tax credit) depends on a number of factors. These factors include your tax filing status (married, single, head of household) and the number of your dependents. Use IRS Form 2441 to help you make this decision or discuss your options with your accountant or other tax advisor.

SECTION 8 – HSA CONTRIBUTIONS

HSAs Generally

Health Savings Accounts (HSAs) allow you to save for unreimbursed medical expenses. Unlike the Health FSA Choice, amounts contributed to your HSA are not forfeited. Instead, they can

stay in your HSA and potentially be invested and grow. However, if you use HSA funds other than to pay or reimburse yourself for qualified medical expenses, then the distribution is included in your income and is subject to an additional 20% penalty tax. Additionally, you cannot get reimbursed from your HSA and a health FSA or health reimbursement arrangement (HRA) for the same expense. You should consult your own tax advisor regaridng whether an HSA makes sense for you.

Contributions and Limits

For administrative convenience, the Company has chosen to allow you to make HSA contributions by pre-tax payroll deduction to HSAs established at a custodian designated by the Company. **You must be enrolled in the Company's HDHP to make payroll deduction contributions to your HSA under the Cafeteria Plan. Your payroll deductions will be forwarded to the designated HSA custodian by direct deposit. However, you must set up your HSA with the designated HSA custodian. The Company cannot set up the HSA for you. If you do not set up your HSA with the designated HSA custodian in a timely manner, your payroll deductions may be returned to you without interest. Returned deductions are subject to withholdings mandated by law, including federal and state income and Social Security tax withholdings, as well as any authorized deductions**.

You will be provided with information about how to set up, access, and manage your HSA account through the designated HSA custodian. An HSA is your individual account. Neither the Company arrangement for making contributions to the HSAs nor the HSAs themselves are welfare benefit plans under the Employee Retirement Income Security Act of 1974.

HSA contributions are subject to the self-only and family maximum amounts allowed by IRS rules and the minimum amount is $100.

If you set up an HSA, the Company will also contribute an amount to your HSA. This contribution will reduce the amount you can contribute. The Company will communicate the amount of its contribution amount prior to your eligibility for coverage as well as during each annual open enrollment period. If your initial enrollment occurs on or after July 1, you are only eligible for one-half of the annual Company contribution amount. To receive this contribution, you must establish your HSA by December 1. If you do not, you will forfeit the Company contribution.

HSAs Are Not Health Plans

Your HSA is an individual account – it is not group-based. You are responsible for managing your HSA, including choosing how your HSA funds are invested and following the rules established by the designated HSA custodian and the IRS. You will request distributions from the HSA custodian. You are responsible for reporting contributions made to your HSA (whether made by you or on your behalf by the Company) and for reporting distributions from your HSA. You must determine whether your HSA distributions are taxable or whether they are used for qualified medical expenses. Only distributions for qualified medical expenses are not taxed by the IRS. It is also your responsibility to maintain receipts demonstrating that reimbursements are for qualified medical expenses.

The HSA custodian may offer investment options for your HSA account balance. The Company does not review, influence, or make any endorsement regarding the investment options or investment of your HSA funds. All investing is subject to risk and your HSA may lose value. You

should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for you.

Once contributions have been deposited in your HSA at the designated HSA custodian, you are free to request a distribution of the funds or move them to another HSA trustee or custodian, to the extent allowed by law. For more information about HSAs, including who is eligible, other health coverage that might disqualify an individual from being eligible, contribution limits, and other rules, see IRS Publication 969 (Health Saving Accounts and Other Tax-Favored Health Plans).

SECTION 9 – PREMIUMS FEATURE

Benefits

The Premiums Feature offers pre-tax payment of your share of the cost of the health plan coverage and/or voluntary accidental death and dismemberment plan coverage offered by the Company, to the extent available under applicable tax laws. The applicable health plan and voluntary accidental death and dismemberment plan documents explain the scope of coverage in detail.

How Premium Payments are Made

Your premium payments automatically will be paid pre-tax by payroll deduction if you enroll in a covered health plan and/or voluntary accidental death and dismemberment plan.

SECTION 10 – CLAIM APPEAL PROCEDURES

If your claim is for a benefit under a Company health plan or voluntary accidental death and dismemberment plan, you should follow the claims procedures in the applicable plan document. These claims procedures also do not apply to your HSA since it is your individual account. However, if you are denied a benefit under this Cafeteria Plan (such as a claim for reimbursement from your Health FSA Account or Dependent Care Account, or a request to change your election), the claims procedure under this Cafeteria Plan will apply.

The Company will notify you in writing within 30 days of the date you submitted your claim if the claim is denied. (The 30-day period may be extended for an additional 15 days for matters beyond the control of the Company, including where a claim is incomplete. The Company will provide written notice of any extension, the reasons for the extension and the date by which a decision by the Company is expected to be made. Where a claim is incomplete, the extension notice will describe the required information and will allow you 45 days from receipt of the notice to provide the required information. The time for deciding your claim will be suspended until the required information is provided.)

Notification of a claim denial will explain: why your claim was denied; the specific plan provision on which the denial is based; additional information necessary for you to validate the claim and an explanation of why such information is necessary; what steps you must take to appeal the claim denial, including your right to submit written comments and have them considered; your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") (only applicable to claims under your Health FSA Account) with respect to any adverse determination after appeal of your claim.

A notification of a claim denial under your Health FSA Account will specify an internal rule, guideline, protocol or other criterion which was relied upon in making the adverse determination (if applicable) and that a copy of that rules, guideline, protocol or other criterion will be provided to you free of charge upon your request. In addition, if you receive a Notice of Denial of a claim under the Health FSA Account which is based on a medical necessity or experimental treatment or similar limits, you will be provided with an explanation of the scientific or clinical judgment for the denial and an explanation applying the terms of the Cafeteria Plan to your medical circumstances will be provided to you free of charge upon your request.

You may request a review any time within the 60-day period (180-day period for claims under your Health FSA Account) after you have received notice that your claim was denied. You or your authorized representative may review relevant documents held by the Company, and you may submit comments and other supporting information. Your written appeal should state the reasons you feel your claim should not have been denied and include additional facts or documents you feel support your claim. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your claim appeal will be reviewed by a named fiduciary of the Cafeteria Plan designated by the Company. If your claim appeal is for benefits under your Health FSA Account, then it will be reviewed by the "Appeals Fiduciary." The Appeals Fiduciary is designated by the Company.

In most cases, a decision will be reached within 60 days of the date of your request for a review. (The 60-day period may be extended for an additional 60 days for matters beyond the control of the Company or Appeals Fiduciary, as applicable. The Company or Appeals Fiduciary, as applicable, will provide written notice of any extension, the reasons for the extension and the date by which a decision by the Company or Appeals Fiduciary, as applicable, is expected to be made.) The Appeals Fiduciary may in its discretion hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth: the specific reasons for the decision on review; the specific plan provisions on which the decision is based; a statement of your right to review (upon request and at no charge) relevant documents and other information; a description of any specific rule or guideline that was relied on and a statement that such rule or guideline will be provided free of charge to you upon request; and a statement of your right to bring suit under ERISA Section 502(a) (only applicable to claims under your Health FSA Account).

If the decision on review of a claim for benefits under the Health FSA Account is based on an internal rule, guideline, protocol or other criterion, the decision will state as such and provide that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon your request. In addition, if the decision on a review for a Health FSA Account affirms the initial denial of your claim based on a medical necessity or experimental treatment or similar exclusion or limit, then it will provide an explanation of the scientific or clinical judgment for the denial and an explanation applying the terms of the plan to your medical circumstances will be provided to you free of charge upon your request. If your claim was denied upon review for a claim for benefits under the Health FSA Account, you will be provided with a statement regarding the availability of other voluntary alternative dispute resolution options available to you.

SECTION 11 – COBRA HEALTH CONTINUATION COVERAGE

"COBRA Health Continuation Coverage" means your right, or your spouse's and dependents' right, to continue the same coverage under any health plan or the Health FSA Choice that was in place the day before a "qualifying event" if participation by you (or your spouse and dependents) otherwise would end due to the occurrence of the qualifying event. This continuation coverage is required by a federal law called "COBRA." A qualifying event is any of the following:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- Your death;
- Divorce or legal separation from your spouse;
- Your becoming entitled to receive Medicare benefits;
- When one of your dependents ceases to be a dependent.

For a qualifying event, other than a change in your employment status, it will be your obligation to inform the plan administrator of your health plan of its occurrence within 60 days of the occurrence. The plan administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue coverage under the health plan at stated premium costs. The notification you will receive will explain all the rest of the terms and conditions of the continued health coverage. For a full explanation of your COBRA Health Continuation Coverage Rights under a Company health plan, you should refer to the applicable plan documents for that health plan.

Certain participants in the Health FSA Choice will be eligible for COBRA Health Continuation Coverage if they have a positive balance in their Health FSA Account at the time of a qualifying event (taking into account all claims submitted before the date of the qualifying event). However, if COBRA is offered for the calendar year in which the qualifying event occurs, COBRA Health Continuation Coverage for the Health FSA Account will cease at the end of the calendar year in which the Qualifying Event occurs. Premiums for such coverage must be paid on an after-tax basis. However, if a participant who elects COBRA continuation coverage has an amount that is eligible for carryover to the following year, coverage under the Health FSA Account will continue until the earlier of the end of the maximum COBRA coverage period that applies or the carryover amount has been completely exhausted. No premiums are required or collected for carryover amounts.

SECTION 12 – YOUR ERISA RIGHTS

Your Rights

The Cafeteria Plan is not an ERISA welfare plan. However, the benefits offered under the Health FSA Choice of the Cafeteria Plan are governed by ERISA. If you participate in the Health FSA Choice, then as a participant in an ERISA-covered plan, you are entitled to certain rights and protection under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing a plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report, if any. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA

You have a right to continue your health plan coverage (and, in some cases, your Health FSA Account) for yourself if there is a loss of coverage under the Cafeteria Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary and the documents governing the Cafeteria Plan on the rules governing your COBRA continuation coverage rights.

Qualified Medical Child Support Order

The health plan extends benefits to a participant's non-custodial child, as required by any qualified medical child support order ("QMCSO"), as defined in ERISA Section 609(a). The health plan has detailed procedures for determining whether an order qualifies as a QMCSO. A QMSCO will be reviewed under the Cafeteria Plan's claim appeal procedures.

Prudent Action by Plan Fiduciaries

In addition to creating rights for participants with Health FSA Accounts, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Cafeteria Plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Health FSA Choice or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Health FSA Choice governing documents or the latest annual report (if any) from the Cafeteria Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that fiduciaries misuse money for benefits under the Health FSA Choice, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued

to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Health FSA Choice, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 13 – GENERAL INFORMATION ABOUT YOUR CAFETERIA PLAN

Plan Information

The name of the Cafeteria Plan is the "Tyson Foods, Inc. Cafeteria Plan."

Plan Identification Number: 551

Plan Year: January 1 through December 31

Plan Sponsor Information: Tyson Foods, Inc.
2200 W. Don Tyson Parkway
Springdale, Arkansas 72764-6999
(855) 328-5291

Employer Identification Number: 71-0225165

Plan Administrator

The Cafeteria Plan is administered by the Company, and the Company is the official plan administrator as defined in ERISA. The Company has full discretion and authority to interpret the Cafeteria Plan, adopt rules for its administration and decide who is eligible to enter the Cafeteria Plan and who is eligible to receive benefits. The Company is responsible for keeping the Cafeteria Plan's records, for distributing information about the Cafeteria Plan to the employees and for filing required forms and reports with federal agencies.

Agent for Service of Legal Process

Legal process may be served on Tyson Foods, Inc., 2200 W. Don Tyson Parkway, Springdale, Arkansas 72762, (855) 328-5291, c/o General Counsel.

SECTION 14 – LIMITED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Compliance with HIPAA

In compliance with the privacy provisions of HIPAA, a federal health law, the Company:

(a) will not use or further disclose protected health information, except as permitted or required by the plan document and the Company's HIPAA Policies and Procedures, as amended, or as required by law;

(b) will not use or disclose protected health information for any employment-related action or decision, or in connection with any other of the Company's employee welfare benefit plans and will restrict access to and use of such information to those employees of the Company and other person specified in the HIPAA Policies and Procedures;

(c) will ensure that any business associate to whom the Company provides protected health information agrees to the restrictions and conditions of the plan document and HIPAA Policies and Procedures, as amended, and such other restrictions as apply to such business associate under HIPAA, with respect to protected health information;

(d) will not use or disclose PHI that is genetic information for underwriting purposes;

(e) will report to the Cafeteria Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed by the plan document and HIPAA Policies and Procedures, as amended;

(f) will make protected health information available to each participant who is the subject of the information in accordance with HIPAA;

(g) will make protected health information available for amendment and, on notice from the Cafeteria Plan, amend a participant's protected health information in accordance with HIPAA;

(h) will track disclosures of protected health information that are not excepted from disclosure accounting as described by the Company's HIPAA Policies and Procedures so that it can make available the information required for the Cafeteria Plan to provide an accounting of disclosures in accordance with HIPAA;

(i) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to the Cafeteria Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA;

(j) if feasible, consistent with applicable record retention requirements, will destroy all protected health information that the Company created or received for or from the Cafeteria Plan when the Company no longer needs protected health information for the plan administration functions for which disclosure was made; and

(k) will take such actions as required by HIPAA to ensure the protection of electronic protected health information.

The information the Company will return or destroy includes all protected health information in whatever form or medium (including any electronic medium), and all copies of and any data or compilations derived from such information that allow identification of any participant who is a

subject of the information. If it is not feasible to destroy all protected health information, the Company will limit the use or disclosure of any participant's protected health information it cannot feasibly destroy to those purposes that make the destruction of the information infeasible.

Reporting of Noncompliance

Any issues of noncompliance with HIPAA should be addressed to the Privacy Officer, c/o Tyson Foods, Inc. Cafeteria Plan, 2200 W. Don Tyson Parkway, Springdale, AR 72762.