TYSON FOODS, INC.
EMPLOYEE ASSISTANCE PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2017

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INTRODUCTION

This summary describes the provisions of the Tyson Foods, Inc. Employee Assistance Plan ("Plan" or "EAP" or "Employee Assistance Plan") which has been adopted to benefit employees of Tyson Foods, Inc. ("Company" or "Tyson").

This summary generally describes the Plan as in effect on January 1, 2017, and every effort has been made to make this summary as correct and complete as possible. However, the Plan's legal documents govern the operation of the Plan and all rights to benefits. *The full Plan document, of which this summary is a part, is the authority for all decisions concerning benefits and other Plan matters. Accordingly, if questions arise, or if a provision of this summary is inconsistent with the formal text of the Plan, all decisions will be based on the formal text of the Plan, which will control in all instances.* The Plan Administrator has the ultimate authority to interpret the Plan and make all determinations thereunder including determinations regarding eligibility, payment of benefits, and subsequent amendments to the Plan not included in this Summary Plan Description.

This summary is intended to provide information and to answer most of the questions you have concerning your EAP. We urge you to read this summary carefully and keep it with your important personal papers.

If you have any questions concerning the Plan, or would like to examine the Plan (which determines your rights), please contact the Tyson Benefits Department.

HOW THE PLAN WORKS

The Company pays the full cost of providing benefits under the Plan. You do not have to pay anything to participate.

The purpose of the EAP is to give you and your "eligible family members" (see "Plan Participation") an opportunity to discuss your work, personal, or family problems with a professional counselor. The EAP offers assessment, short-term counseling, referral and case management services. Benefits are provided through Health Advocate, Inc. ("Health Advocate").

Your EAP counselor will help you or your eligible family members assess your problem and develop a plan of action. Services may include short-term counseling with an EAP counselor. In some cases, you and/or your eligible family member(s) may need to be referred to an individual or organization in the community for longer-term or specialized treatment. Most people find that the services provided are helpful, but occasionally a person's situation may not improve. If you have concerns about the risks associated with counseling, please discuss your concerns with your EAP counselor.

If a referral is made to a provider who is not part of the EAP, the financial responsibility for payment to the referral source is yours. If you are enrolled in the major medical benefits portion of the Tyson Foods, Inc. Group Health Plan (the "Medical Benefits"), the Medical Benefits may cover some of the cost of the services provided by the non-EAP provider. You are not required to exhaust benefits under the EAP to access Medical Benefits. Your EAP counselor will have a broad outline of the Company's Medical Benefits. Your EAP counselor may also refer you to other benefit providers for Tyson benefit plans, such as prepaid legal services. However, coverage under the Company's Medical Benefits or other benefit plans can only be determined by reviewing the applicable plan's documents. EAP counselors are not authorized to approve eligibility for Medical Benefits or any other Tyson benefits.

The information that you give to your EAP counselor is private and confidential. Health Advocate generally will not release information to anyone outside Health Advocate (including the Plan and the Company) without your written permission. Health Advocate may be required or permitted to release information to third parties (not including the Plan or the Company) without your permission. The circumstances governing these releases of information are described in the Health Advocate Notice of Privacy Practices ("Notice"). Your EAP counselor is required to give you a copy of this Notice when you utilize any of the benefits of the Plan. The Notice can also be found on the Health Advocate website at www.healthadvocate.com.

If at any time you have concerns about the service or you are dissatisfied with an outside referral, you are encouraged to discuss the matter immediately with any of the EAP counselors. If you think that Health Advocate has not handled your information in accordance with the Notice, notify Health Advocate's privacy official at Health Advocate, Inc., 3043 Walton Road, Plymouth Meeting, PA 19462 or by calling (866) 695-8622 and asking to speak with Health Advocate's privacy official.

PLAN PARTICIPATION

All full- and part-time employees are eligible to participate in the EAP. The Plan's benefits are also available to your spouse, your children under age 23 who live with you or who are at college, your parents, and your parents-in-law. They are your "eligible family members." You and your eligible family members can participate, even if you or they are not enrolled in Medical Benefits through Tyson.

Additionally, you and your eligible family members will continue to be eligible to participate for up to 36 months following your termination of employment on the same terms as if you were an active employee. Further, your eligible family members will be allowed to continue to be eligible to participate for up to 36 months after the following events:

- Your death;
- Your spouse's divorce from you; or
- In the case of a child, the date the child is no longer eligible because he or she turns age 23, moves outside your house, or is no longer at college.

You or your eligible family members should give notice to the Tyson Benefits Department of the above events.

There is no cost to employees and eligible family members for the initial evaluation, counseling and referral services offered by the EAP.

BENEFITS

The Company recognizes that a wide range of personal problems can affect an employee's or eligible family member's job performance or quality of life. Examples of such personal problems include: alcoholism, other drug dependencies, marital or family distress, emotional instability, financial or legal problems.

In many instances, the employee or eligible family member will overcome such problems independently, and the effect on job performance or quality of life will be negligible. In some cases, however, additional help is needed to overcome these types of problems.

The purpose of the Plan is to help the employee or eligible family member overcome his/her problem and hopefully restore that person to acceptable job performance or quality of life. The Plan is designed to help the employee or eligible family member to identify the problem at the earliest possible stage, motivate the person to seek help, and to direct the person to the appropriate assistance.

You and your eligible family members can request help for a variety of personal problems. Health Advocate provides the following services to assist you and your eligible family members

The Health Advocate Basic EAP Service:

a. A 24-hour Emergency Hot Line;
b. Unlimited Telephonic Critical Incident Stress Debriefing Support;
c. Professional telephone evaluation for the nature and scope of employee personal problems, and referral, if needed, to appropriate professional counseling or other necessary care;
d. In-Person Sessions ("Sessions") assessment and short-term problem resolution by network of qualified EAP consultants. The number of Sessions is up to 3 per problem;
e. Case management for inpatient and outpatient treatment; and
f. Unlimited Telephonic Manager Consultations and mandatory referrals.

Access to Health Advocate Telephonic and Web Based Support for Work/Life Services:

a. Childcare**:** Child Care Centers, Family Child Care Homes, Nanny Agencies, Summer Camps, Babysitter Tips, Community Resources;
b. Eldercare**:** Nursing Homes, Assisted-Living Facilities, Independent Living Facilities, Home Healthcare, Hospice, Respite Care, Geriatric Care Managers, Senior Centers, Adult Day Care Centers, Community Services and Resources;
c. Legal: Family Law Issues, Real Estate, Criminal Matters, Estate Planning, Motor Vehicle, Elder Law;
d. Financial: Debt Management, Budgeting, College Funding, Retirement Strategies, Life Insurance Needs; and
e. Unlimited Telephonic and Web Based Consultation.

The Work/Life Services include the following types of services:

i. Short-term counseling focused on coping strategies.
ii. Licensed counseling for stress, depression, family issues, substance abuse and more.

iii. Referral for long-term counseling or specialized care, as needed through Client network providers.
iv. Work/life specialists locate, determine availability for eldercare, childcare, legal and other support services.
v. Access to website to self-search work/life provider databases, articles, webinars and onsite seminars.
vi. Critical incident planning and initial disability consultations involving mental health or substance abuse.
vii. In-person or telephonic counseling, 24-hour emergency service and other features available to employees and eligible family members living/working outside the U.S.

Other Available Worldwide Services Provided by Health Advocate

i. Toll-free hotlines and collect call numbers available to employees.
ii. Telephonic or in-person counseling provided in English or the local language.
iii. A network of local multi-disciplinary counselors in over 150 countries.

Additional Benefits

i. Personal Concierge Service – As part of the EAP Work/Life program, you and your eligible family members have access to a team of luxury lifestyle experts, for individual help with a wide range of personal tasks including, but not limited to: travel research and bookings, restaurant reservations, party/event planning, ticketing, sporting events, and more.
ii. Video Counseling Services – The EAP Work/Life program offers employees and their eligible family members access to confidential video counseling with a mental health counselor over their computer, laptop, tablet or smartphone with available tech support. Video counseling services are in place of a face to face Session and count toward the three-Session limit for each problem. Counselors are master level clinicians licensed in the state in which the member resides.

No employee will have his/her job security or promotional opportunities jeopardized for participating in the Plan.

Confidentiality of your information is essential and will be maintained by Health Advocate, subject to the terms of the Notice. Neither the Plan nor the Company will receive any information about you or your use of EAP benefits unless it is required by law and explained in the Notice.

Employees and their eligible family members are encouraged to use the EAP voluntarily when they need professional help or guidance.

Procedures

Any employee of the Company, or his or her eligible family members, may use the EAP on a self-referral basis by contacting Health Advocate at 877-240-6863.

SITUATIONS AFFECTING PLAN BENEFITS

Some situations could affect Plan benefits. Those situations are summarized here.

Notice of Address

If you or your eligible family member does not keep an up to date address on file with the Tyson Benefits Department and the Benefits Department cannot locate you, benefits may be delayed. Accordingly, you need to keep the Benefits Department apprised of your current address.

No Right to Employment or Benefits

The Plan and this SPD will not be construed to give you any right to be retained in the Company's employ nor any right or claim to a benefit unless the right to such benefit is in accordance with the Plan's terms.

No Obligation to Continue Plan

While Tyson currently intends to continue the Plan indefinitely, it can amend or terminate the Plan at any time and for any reason. If the Plan is terminated, you and your eligible family members will not be able to receive benefits after the Plan's termination.

BASIC ADMINISTRATIVE INFORMATION

The EAP Plan's sponsor, plan administrator, claims administrator, trustee, and other administrative information is included in this section.

Name of Plan

Tyson Foods, Inc. Group Health Plan

EAP Plan Sponsor

Tyson Foods, Inc.
2200 W. Don Tyson Parkway
Springdale, AR 72762

Sponsor's Employer Identification Number

71-0225165

Plan Number

501

Plan Administrator

Tyson Foods, Inc.
2200 W. Don Tyson Parkway
Springdale, AR 72762
855-328-5291

The Plan Administrator is appointed by Tyson and is ultimately responsible for the administration of the Plan.

Claims Administrator

HMS/Health Advocate, Inc.
3043 Walton Road
Plymouth Meeting, PA 19426
877-240-6863

The Claims Administrator is appointed by the Plan Administrator and is responsible for a wide range of duties, including interpreting Plan provisions, maintaining records, and determining your eligibility for benefits.

Plan Trustee

Because the Plan holds no assets, there is no trust fund for the Plan.

Agent for Service of Legal Process

Tyson Foods, Inc.
c/o General Counsel
2200 West Don Tyson Parkway
Springdale, Arkansas 72762
855-328-5291

Legal process can also be served on the Plan Administrator at the address shown above.

Bargaining Agreement

The Plan is not maintained pursuant to any collective bargaining agreement.

Plan Year

The Plan Year is the calendar year, January 1 through December 31.

Plan Amendment and Termination

The Company may amend or terminate the Plan at any time for any reason, with or without notice. No employee or eligible family member has any vested right to benefits under the EAP.

Administration

The Plan is administered by the Claims Administrator with oversight from the Plan Administrator. The administrative duties of the Claims Administrator include interpreting the Plan, prescribing application procedures, determining right to and amount of benefits, authorizing benefit payments, and gathering of information necessary for administration of the Plan. Appropriate forms available for processing claims can be obtained from the Claims Administrator.

Claims Procedure

UNLESS PROHIBITED BY LAW THE CLAIMS PROCEDURES IN THIS SECTION MUST BE USED BEFORE A LAWSUIT RELATED TO THIS PLAN CAN BE FILED

Any eligible employee or eligible family member, or someone claiming benefits on an eligible employee or family member's behalf, may file a claim with the Claims Administrator for benefits or for a greater amount of benefits. For purposes of this Claims Procedure section, we refer to any person claiming benefits under the Plan as "the claimant." The claim must be in writing and must contain the following information:

(i) a description of the claim;
(ii) the facts supporting the claim;
(iii) the amount claimed; and
(iv) the name and address of the person filing the claim.

The Claims Administrator will designate a representative to answer the claim in writing or electronically within 60 days (or 45 days if special circumstances require an extension of time and the claimant is so notified prior to the termination of the initial 60-day period). The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan is expected to render a decision If a time period is extended due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If the claim results in an adverse benefits decision, the claimant will be provided with a written or electronic notice containing:

(i) the specific reasons for the denial;
(ii) references to the specific provisions in the Plan document on which the denial is based;
(iii) a description of any additional information needed to grant the claim and an explanation of why the additional information is needed;
(iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA section 502(a);
(v) if applicable, either a description of the rule, guideline, protocol, or similar criteria on which the denial is based or a statement that a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request.

If a notice of benefit determination is not provided within these time periods, the claimant can treat the claim as if an adverse benefit determination had been made (that is, as if it was denied).

The claimant has the right to appeal an adverse benefit determination. To appeal the adverse benefit determination, the claimant must file a written request for appeal with the Claims Administrator within 180 days after receiving notice of the adverse benefit determination. This written request for appeal should contain:

(i) a statement of the grounds on which the appeal is based;
(ii) reference to the specific provisions in the Plan document on which the appeal is based;
(iii) the reason or argument why the claimant feels the claim should be granted and the evidence supporting each reason; and
(iv) any other documents, comments or information the claimant wishes to submit to support the appeal.

If the claimant is seeking review the claimant will (1) have the opportunity to submit written comments, documents, records, and other information relating to the claim, and (2) be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The review shall take into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If necessary to comply with applicable federal law, the claim will

be reviewed by a Plan fiduciary who is not the same person, or subordinate of the person, who reviewed the initial claim.

The Claims Administrator will notify the claimant of the benefit determination on within 60 days of the Plan's receipt of the request for review. The Claims Administrator will provide the claimant with electronic or written notification of the determination on review. If the determination on review is adverse, the Claims Administrator's notification will include:

(i) specific reasons for the adverse determination;
(ii) references to the Plan provisions supporting the adverse determination;
(iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about these procedures and a statement of the claimant's right to bring an action under section 502(a) of ERISA; and
(v) if applicable, either a description of the rule, guideline, protocol, or similar criteria on which the denial is based or a statement that a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request

In the case of an adverse benefit determination on review, the Claims Administrator shall provide the claimant access to, and copies of, documents, records, and other information relevant to the claim as is appropriate.

The Claims Administrator has the discretion to determine eligibility for benefits and the amount of benefits payable, both initially and on review, make factual determination and construe the terms of the Plan. Such determinations and constructions shall be conclusive and binding on all persons and entities.

The Claims Administrator shall have the discretion to construe the terms of the Plan, to make factual determinations, and to determine all questions arising in the administration, interpretation, and application of the Plan both initially and on review. Such determinations and constructions shall be conclusive and binding on all persons and entities.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

(i) examine, without charge, at the Plan Administrator's office all Plan documents, insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and this SPD;

(ii) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies;

(iii) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to annually furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a welfare 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 these rights. For instance, if you request a copy of Plan documents or the latest annual report from the 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, 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.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.