

# Tyson Foods, Inc. Group Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2019-12/31/2019

Plan Type: Preferred Provider Organization (PPO)

Coverage for: Team member only, Team member + Child(ren), Team member + Spouse and Team Member + Spouse and Child(ren)



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your local Benefits Coordinator or log onto the Tyson Benefits website. For general definitions of common terms, such as plan allowance, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary on the Tyson Benefits Website or call your local Benefits Coordinator to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For <u>network providers</u> \$1,100 individual / \$2,200 family; for <u>out-of-network providers</u> \$1,100 individual / \$2,200 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. There is a \$50 <u>deductible</u> for all <u>out-of-network</u> pharmacy benefits.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For medical <u>network providers</u> \$5,000 individual / \$10,000 family; for prescription drug services \$2,150 individual / \$4,300 family, separate from medical. There is no <u>out-of-pocket limit</u> for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count towards the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Visit the website or call the number on the back of your insurance ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (a <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Questions: Call BlueAdvantage Administrators of Arkansas at 800-452-6199. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary on the Tyson Benefits Website or call your Benefits Coordinator at your work location to request a copy.

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All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /office visit; 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copay</u> applies when service is provided by an OB/GYN, pediatrician, internist, family practice, physician assistant or nurse practitioner.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge for covered services	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage includes a second opinion

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available on the Tyson Benefits intranet.	Generic drugs	•20% <u>coinsurance</u> /\$10 minimum, \$20 maximum (up to 30 day supply) at Tier 1 pharmacies •30% <u>coinsurance</u> /\$20 minimum, \$40 maximum (up to 30-day supply) at Tier 2 pharmacies •20% <u>coinsurance</u> /\$20 minimum, \$40 maximum (up to a 90-day supply)	After \$50 <u>deductible</u> , 50% of network pharmacy price, plus any difference between the <u>network</u> pharmacy price and the non-network pharmacy price.	Select generic maintenance medications have \$0 <u>copay</u> when purchased through the CVS Mail-Order Program or at a Tier 1 Retail Pharmacy. Refill limits apply for 30-day supplies of maintenance medications filled at pharmacies other than Tier 1 Retail Pharmacies,
	Preferred brand drugs	•20% <u>coinsurance</u> /\$30 minimum, \$60 maximum (up to 30 day supply) at Tier 1 pharmacies •30% <u>coinsurance</u> /\$60 minimum, \$120 maximum (up to 30-day supply) at Tier 2 pharmacies •20% <u>coinsurance</u> /\$60 minimum, \$150 maximum (up to a 90-day supply)	After \$50 <u>deductible</u> , 50% of <u>network</u> pharmacy price, plus any difference between the network pharmacy price and the non-network pharmacy price.	If a brand-name drug is filled when a generic equivalent is available (for any reason), you pay the difference in cost of the brand-name drug plus the higher brand <u>copay</u> .
	Non-preferred brand drugs	•20% <u>coinsurance</u> /\$135 minimum, \$240 maximum (up to 30 day supply) at Tier 1 pharmacies •30% <u>coinsurance</u> /\$200 minimum, \$360 maximum (up to 30-day supply) at Tier 2 pharmacies •20% <u>coinsurance</u> /\$270 minimum, \$485 maximum (up to a 90-day supply)	After \$50 <u>deductible</u> , 50% of <u>network</u> pharmacy price, plus any difference between the network pharmacy price and the non-network pharmacy price.	If a brand-name drug is filled when a generic equivalent is available (for any reason), you pay the difference in cost of the brand-name drug plus the higher brand <u>copay</u> .
	<u>Specialty drugs</u>	Generic: \$75 <u>copay</u> Preferred brand: \$100 <u>copay</u> Non-preferred brand: \$125 <u>copay</u>	Not covered	Coverage is limited to a 30-day supply purchased through CVS Caremark Specialty pharmacy

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	First 2 visits: \$100 <u>copay</u> ; 3+ visits: \$200 <u>copay</u> , then <u>deductible</u> and 20% <u>coinsurance</u>	First 2 visits: \$100 <u>copay</u> ; 3+ visits: \$200 <u>copay</u> , then <u>deductible</u> and 50% <u>coinsurance</u>	<u>Copay</u> waived if admitted. <u>Out-of-network emergency services</u> may be paid at <u>in-network</u> rates if the condition is an emergency, but can be <u>balance billed</u> . Final determination will be made by the Claims Administrator.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to transportation to the nearest facility and excludes ambulance services when the patient could be safely transported by other means.
	<u>Urgent care</u>	\$50 <u>copay</u>	50% <u>coinsurance</u>	<u>Coinsurance</u> applies when services are not billed as an office visit.
	<u>Telemedicine visit</u>	\$20 <u>copay</u>	Not covered	Includes access to psychologists
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage includes a second opinion
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Including residential treatment for substance abuse treatment. <u>Preauthorization</u> is required.
If you are pregnant	Office visits	\$35 <u>copay</u> /office visit; 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Charges for a dependent newborn child will be separate from the mother's charges, and will apply toward the family <u>deductible</u> and <u>out-of-pocket limit</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to when provided by a licensed <u>home health care</u> agency, and the patient is under the care of a physician. Limited to 60 visits/calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Speech therapy 30 visits/calendar year. Occupational therapy, physical therapy and chiropractic therapy limited to a combined 30 visits /calendar year. Inpatient <u>rehabilitation services</u> limited to 60 days/calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled Nursing Care &amp; Long-Term/Acute Care (LTAC)</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 days/calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Six (6) month limited benefit for participants with an estimated life expectancy of six (6) months or less, as attested by the physician treating the illness
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u>	Charges in excess of \$50	Coverage limited to one exam every 12 months.
	Children's glasses	\$25 <u>copay</u> plus charges in excess of \$75 for frames	Charges in excess of: • \$50 for single vision lenses; • \$75 for bifocal lenses; • \$100 for trifocal lenses; and • \$60 for frames	Coverage limited to one pair of glasses every 24 months.
	Children's dental check-up	No charge	Any amount charged in excess of the <u>Plan Allowance</u> .	Limited to twice/calendar year

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### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                     |                                |                                     |
|---------------------|--------------------------------|-------------------------------------|
| • Acupuncture       | • Hearing aids                 | • Routine eye care (Adult)          |
| • Bariatric Surgery | • Long-term and Custodial care | • Routine foot care                 |
| • Cosmetic Surgery  |                                | • Weight loss services and programs |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |   |   |   |
|---|---|---|
| • Chiropractic care – combined with occupational therapy and physical therapy, coverage is limited to 30 visits per calendar year | • Non-emergency care when traveling outside the U.S. – except if for the sole purpose of obtaining medical care | • Private-duty nursing – coverage is limited to when approved through <u>Home Health Care</u> Plan. |
| • Dental care (Adult)   |   |   |

**Your Rights to Continue Coverage:** If you lose coverage under the plan, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health care coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BlueAdvantage Administrators of Arkansas at 800-452-6199.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 479-290-4000.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 479-290-4000.]

[Chinese (中文): 如果需要中文的帮助, ☐☐打☐个号☐479-290-8476.]

[Navajo (Dine): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 479-290-4000.]

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery. Dependent newborn charges are separate.)

■ The plan's overall <u>deductible</u>	\$1100
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,100
Copays	\$210
Coinsurance	\$2,298
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,608

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1100
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,100
Copays	\$560
Coinsurance	\$1,148
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,808

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1100
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copays	\$100
Coinsurance	\$140
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,340

The plan would be responsible for the other costs of these EXAMPLE covered services.