SMITHFIELD FOODS HEALTH CARE PROGRAM

FOR HOURLY EMPLOYEES OF

SMITHFIELD PACKING COMPANY, INC.

SMITHFIELD SOUTH

PLAN DOCUMENT AND

SUMMARY PLAN DOCUMENT

(EFFECTIVE JANUARY 1, 2013)
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SUMMARY SCHEDULE OF BENEFITS

1. **Annual Deductibles**  
   - $250 per Member per calendar year for services rendered by Network Providers. The Network Service Area is listed on Schedule C.  
   - No benefits are available for services rendered by Non-Network Providers (except $250 per Member per calendar year when applied to Covered Services that the Plan Administrator determines not to be available from any appropriate Network Provider located within 50 miles of the Member's primary residence, or to be true Emergency Services provided by a Non-Network Provider that is nearer to the location of the Member than any appropriate Network Provider).  
   - The $250 Annual Network deductible (and if applicable, the $250 Annual Non-Network Deductible) do not apply to Preventative Care Services per covered adult Member (Employee and Employee’s spouse only), as well as additional preventative care and screenings for women and per covered Child Member as long as they fall under the federal regulations. To obtain more information on eligible covered preventative care services, please visit [www.healthcare.gov/prevention](http://www.healthcare.gov/prevention).

2. **Lifetime Maximum Benefit - Per Member** – No Lifetime Maximum

3. **Copayments (General)** – Vary depending upon provider and type of service. See listing of Copayments contained in Schedule D.

4. **Benefit Limits/Certain Copayments**
   - **Hospital Daily Room and Board**: The average semiprivate room rate in locality. If medically necessary, allows for the difference of private room rate in locality.
   - **Physician Services**: See Copayment Schedule D attached.
   - **Intensive Care Unit**: Hospital ICU charge.
   - **Skilled Nursing Facility**: The facility's average semiprivate room rate in locality for a maximum of 60 days per calendar year.
   - **Home Health Care**: Maximum of 40 visits (four hours equals one visit) per Calendar Year.
   - **Hospice Care**: $150 per day maximum.
   - **Ambulance Service**: The usual and reasonable charge per trip.
   - **Spinal Manipulation/Chiropractic**: 18 visits per plan year and $25 maximum payment per visit.
Hearing Aids: $1,500 maximum payment per ear, every five years.

Organ Transplant: No coverage of donor costs unless services are through a Center of Excellence provider.

Obesity Treatment and Bariatric Surgery: Treatment and services related to obesity treatment and Bariatric surgery are subject to a maximum one per lifetime. No coverage unless services are through a Center of Excellence provider.

Dialysis Treatment: All dialysis treatment and services related to dialysis treatments (including hemodialysis and peritoneal dialysis) are subject to a maximum coverage period of nine months.

Emergency Room Services: See Copayment Schedule D attached. Must be a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) placing the health of the individual in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part and requires the Member to seek immediate medical attention.

Psychiatric Care: Outpatient: See Copayment Schedule D attached.
               Inpatient: See Copayment Schedule D attached.

Substance Abuse: See Copayment Schedule D attached.
INTRODUCTION

The Smithfield Foods Health Care Program (the "Program") is designed to provide medical and short-term disability benefits to eligible employees of Smithfield Foods, Inc. (or "Smithfield" or the “Company”) and its wholly-owned subsidiaries. The Program also provides medical benefits to the eligible dependents of such workers. The Program is sponsored by Smithfield Foods, Inc and is self-insured. No commercial health insurance company is responsible for financing or administering the Health Care Program.

The Smithfield Foods Health Care Program for Hourly Employees of Smithfield Packing Company, Inc. Smithfield, Virginia (the "Plan") provides benefits to eligible full-time hourly employees of the Smithfield, Virginia division, South plant and facilities of Smithfield Packing Company, Inc. (collectively "Smithfield") a Smithfield subsidiary, in accordance with the terms of the collective bargaining agreement (“Collective Bargaining Agreement”) between Smithfield Packing and The Food Processors Local Union Number 1046, Laborer’s International Union of North America, AFL-CIO (“Union”). Separate plans are applicable to other employees of Smithfield Foods, Inc. and/or its subsidiaries and are described in separate documents applicable to those other employee groups.

The "Plan Administrator" is Smithfield Foods, Inc., which administers the Plan.

If you have any questions regarding the Plan, wish to confirm coverage or desire further information contact the Plan Administrator at 1-800-809-5916.

This document serves as the Plan document and Summary Plan Description ("SPD"). Smithfield retains the right to provide additional materials that supplement, update, or amend the Plan document and SPD. Although the Company expects the Plan to continue, the Company reserves the rights to amend, modify, suspend, or terminate the Plan in whole or in part at any time.

ELIGIBILITY

Who is Eligible - Full-Time Hourly Employees of Smithfield

Subject to the enrollment rules described below, you can elect coverage under the Plan on the first of the month following your completion of four (4) continuous months of regular full-time active employment with Smithfield as an hourly employee working at least (30) hours per week. If you meet those requirements, you are an "Eligible Employee." No part-time, seasonal or temporary employees are eligible for coverage under the Plan. The four (4) month waiting period is measured from your most recent employment starting date. This means that if you cease employment with Smithfield and are subsequently rehired you must again satisfy the Plan's eligibility requirements as well as the Annual Deductible, Benefit Limits, and Out-of-Pocket limitations described herein.

Who is Eligible - Dependents

If you are an Eligible Employee and you have properly enrolled in the Plan, you can also obtain medical coverage under the Plan for the following dependents:
o your lawful spouse, excluding common law spouses, provided you are not separated or divorced;

o Lawful spouses as defined above who are not employed or who are employed but not eligible for employer sponsored health care coverage from their employer are eligible for primary medical coverage under the Plan;

o Lawful spouses as defined above who are employed and eligible for health care coverage with their employer are eligible for secondary medical coverage under the Plan;

o your Children until they attain age 26; and

o your Children who are mentally or physically incapable of earning their own living and are disabled for Social Security purposes. Their coverage can be continued beyond age 26 if they first become disabled while covered under the Plan prior to attaining age 26 and you provide proof of their disability and inability to be self-supporting.

An individual may not be covered both as an Eligible Employee and as a dependent under the Plan. An individual may not be covered as a dependent of more than one Eligible Employee under the Plan.

"Children" as described in Section 152(f)(1) of the Internal Revenue Code, means natural son or daughter, adopted sons and daughters or individual lawfully placed for legal adoption by the employee, stepsons or stepdaughters (child of your lawful spouse, excluding common law spouses), foster children lawfully placed with the employee by an authorized placement agency, court judgment, decree or other legal order.

**Note - No person is eligible for coverage while on active duty with the U.S. armed forces.**

**Enrollment**

If you are an Eligible Employee, you must timely enroll under the Smithfield Foods, Inc. Premium Payment Plan ("Cafeteria Plan") to join the Program and receive coverage. The Cafeteria Plan is summarized in a separate booklet available from the Plan Administrator.

You may enroll under one of six coverage types:

- Type 1 - Employee only coverage;
- Type 2 - Employee plus one Dependent;
- Type 3 - Employee plus two Dependents;
- Type 4 - Employee plus three Dependents;
- Type 5 - Employee plus four Dependents; or
○ Type 6 - Employee plus five or more Dependents.

○ If your spouse is employed and is eligible for coverage from their employer, they are not eligible to enroll for primary coverage with Smithfield. If you want to enroll them as a dependent under the Plan, your spouse is required to enroll in their employer’s plan first. Your spouse’s employer’s plan will be the primary coverage and Smithfield will be the secondary coverage.

If you and your spouse are both Eligible Employees, you must each enroll for Eligible Employee coverage (that is, with neither of you being enrolled as a dependent). If you both enroll as Eligible Employees, your Children may only be enrolled as dependents on one plan (that is, children may only be enrolled once).

The Plan will not restrict enrollment or adjust premiums on the basis of genetic information.

**Initial Enrollment**

For the first calendar year in which you are eligible, you (and if applicable, your dependents) must enroll with the Plan Administrator not later than 31 days after becoming eligible by properly completing and returning the enrollment forms provided by Smithfield to include required dependent eligibility supporting documents. Similarly, your eligible dependents are not covered unless you have properly enrolled them by timely filing enrollment forms and supporting documents with Smithfield.

**Open Enrollment - Annual**

If you do not enroll during that initial enrollment period, or a special enrollment period (described below), you (and your dependents) may enroll for a subsequent calendar year during the open enrollment period proceeding that year.

**Special Enrollment - Lapse of Other Coverage**

If you decline coverage for yourself and/or your dependents at a time when you and/or they are eligible for other group health plan coverage, and the other coverage subsequently lapses or is canceled, you may elect to enroll yourself and/or your dependents when that other coverage ends. You must submit your special enrollment election by written notice to the Plan Administrator within 31 days after the other group health plan coverage lapses or is canceled. Otherwise you must wait to the next annual open enrollment to elect coverage.

**Special Enrollment - New Dependents**

If you do not have coverage for yourself and/or your dependents and subsequently marry or have a new Child or dependent (by birth, marriage, adoption or placement for adoption) you may elect within 31 days after the event, (by written notice to the Plan Administrator) to receive Plan coverage for yourself and/or your dependents.
Special Enrollment – CHIPRA

If you decline coverage for yourself and/or your dependents and subsequently you and/or your
dependents become ineligible for Medicaid or a state Child health program or become eligible
for Medicaid or state premium assistance subsidy with respect to Plan contributions, you may
elect within 60 days of the event (by written notice to the Plan Administrator) to receive Plan
coverage for yourself and/or your dependents.

**It's important for you to know that coverage will not begin, and you will not be covered under the Plan, if you fail to timely enroll in the Plan.**

Once enrolled, you will receive an identification card. In the event that you move or lose your
card, contact the Plan Administrator.

When Employee Coverage Begins

Your coverage will start under the Plan as of the first day of the calendar month after you
complete four (4) continuous months of eligible employment if you properly enroll in the Plan
not later than 31 days after the initial four (4) month period and if you are an active Smithfield
hourly employee on that enrollment effective date. If you wait until the annual open enrollment
to elect coverage, your coverage will begin at the beginning of the Plan year (calendar year) after
you return your enrollment forms electing coverage. If you specially enroll on account of
acquiring a new dependent through birth, marriage, placement for adoption, or adoption, your
coverage will begin on the first day of your special enrollment event, provided your enrollment
forms electing coverage are received within 31 days of the special enrollment event. If you
specially enroll for any other reason, your coverage will begin on the day of your special election
event, provided your enrollment forms electing coverage are received within 31 days of the
special enrollment event.

When Dependent Coverage Begins

Your eligible dependents will start coverage on the effective date of your initial enrollment if
they are properly enrolled at that time. If you do not properly enroll your eligible dependents at
the time of your initial enrollment, they can start coverage during any subsequent calendar year
provided they are timely and properly enrolled during the open enrollment period proceeding
that subsequent year. Your dependents can also commence coverage if you properly enroll them
within 31 days after a lapse or cancellation of other group health plan coverage (See "Special
Enrollment - Lapse of Other Coverage" above). Your new dependents can commence coverage
if you properly enroll them within 31 days after the date they become dependents (See "Special
Enrollment - New Dependents" above). If you specially enroll a dependent, enrollment will be
effective on the day of their special enrollment event, provided your enrollment forms and
supporting documents are received electing coverage within 31 days of the special enrollment
event.
**If There Are Changes In Your Family**

You may commence or modify your coverage election on account of any of the following "family status" changes if your new or modified election is consistent with the status change, but only if you notify Smithfield of your new or modified election within 31 days after the status change.

- marriage, divorce, separation, death, annulment, or other change in marital status;
- birth, adoption or change in custody of a Child;
- a Child marries, or reaches age 26;
- a Child who is incapacitated reaches age 26 and you want to continue his/her coverage under the Plan;
- death of your spouse or Child;
- lapse of other group health plan coverage on you and/or your dependents that was in effect when you initially declined Plan coverage;
- you or your dependent terminates or commences employment;
- you or your dependent becomes, or ceases to be, eligible for coverage under the Health Care Program or a medical benefit plan of the dependent's employer; because of a change in employment status, such as a change from full-time to part-time employment or from hourly employment to salaried; or
- you or your dependent becomes enrolled in, loses coverage under, Medicare Part A or Part B (other than the pediatric vaccines program) or Medicaid.

**If There Are Coverage Changes**

You may make a prospective election change that is on account of and corresponds to a change made under a group health plan of your spouse's, former spouse's or dependent's employer under the following circumstances. The change made under the spouse's, former spouse's or other dependent's plan must be one that was permitted under the Treasury Regulations governing employer "cafeteria" plans on grounds of having a new dependent, the loss of other coverage, a family status change, a court order, entitlement to Medicare or Medicaid, significant cost or coverage changes or leave under the Family and Medical Leave Act.

**Court Orders Affecting Children**

The Plan may be required to provide coverage for your Child or foster Child if a judgment, decree or order resulting from a divorce, separation, annulment or change in custody requires coverage of the Child. You may obtain, without charge, from the Plan Administrator a copy of the Plan's procedures governing qualified medical Child support orders. You may elect to cancel coverage under the Plan for a dependent or foster Child if a judgment, decree or order resulting
from a divorce, separation, annulment or change in legal custody requires your spouse or former spouse or another individual to provide health coverage for the Child.

**TERMINATION OF COVERAGE**

Unless you choose to continue your coverage under the COBRA Continuation Coverage rules described below, your coverage under the Plan as an Eligible Employee will terminate on the first of the following:

- The date the Plan terminates;
- The date you cease to be an Eligible Employee or, if earlier, cease to be enrolled in the Plan; or
- The due date for any required Member premium payments to the Plan which you fail to pay.

Unless coverage continues under COBRA, an individual's coverage under the Plan as a dependent will terminate on the first of the following:

- The date the Plan terminates;
- The date that coverage under the Plan terminates as to the Eligible Employee with respect to whom the dependent is enrolled;
- The date the dependent ceases to be enrolled in the Plan;
- The due date for any required employee premium payment to the Plan which the employee fails to pay;
- The date the individual ceases to be an eligible dependent; or
- The date the dependent becomes covered as an Eligible Employee.

Your coverage also will terminate if you cause or allow incorrect or incomplete information to be furnished to the Plan Administrator in connection with the Plan or fail to cooperate in the administration of the coordination of benefits, subrogation, or other provisions of the Plan.

If you fail to pay any required premium for coverage, your benefits will be suspended until the premiums are paid or your claims incurred in that period will be denied if the premium is not paid within 90 days.

The Plan provides no retiree or lifetime health benefits.

**COST OF COVERAGE**

The cost of coverage under the Plan is shared by you and Smithfield. You pay your portion of the cost of Plan coverage under the Cafeteria Plan. The premium schedule will be set in
accordance with the Collective Bargaining Agreement between Smithfield Packing and the Union.

**PLAN MEDICAL BENEFITS - GENERAL**

Subject to the other terms, conditions and exclusions described below, the Plan will pay a portion of the usual and reasonable charges that you incur while covered as an enrolled participant (or "Member") for medically necessary services ("Covered Services"). The maximum portion of your covered expenses that the Plan will pay is the balance of the charges incurred after you have paid the Annual Deductible (see below) and any applicable Copayment and penalties.

**Copayments which you must make for Covered Services vary depending upon the identity of the provider, type of service rendered and location. See Schedule D attached to this summary for a listing of current Copayments.**

**Benefits for surgery (inpatient and outpatient), hospital and nursing facility confinements, drugs and medicines, MRI's, PET scans, sleep disorders, and durable medical equipment purchases over $500 are subject to advance review under the plan's "U.R. Program" and substantial penalties apply if you do not follow the U.R. Program procedures. (See "U.R. Program" below).**

**COVERED SERVICES**

Subject to the Exclusions listed on Schedule A and other terms and conditions of the Plan document, Covered Services are:

1. **Physician Services.** Rendered by a licensed physician for:

   a. Home and office visits for diagnosis and treatment of an injury or physical illness;

   b. Telemedicine or telemediated calls as appropriate for diagnosis and treatment of an injury or physical illness;

   c. Office surgery;

   d. Professional services received in conjunction with inpatient, skilled nursing, emergency room, ambulatory surgery center, or outpatient services;

   e. Preventative Care Services per covered adult Member (Employee and Employee’s spouse only), as well as additional preventative care and screenings for women and per covered child Member as long as they fall under the federal regulations. To obtain more information on eligible covered preventative care services, please visit [www.healthcare.gov/prevention](http://www.healthcare.gov/prevention).

**Chiropractors are not considered physicians under the Plan, but chiropractor services are covered as provided below under "Spinal Manipulation/Chiropractic Services."**
2. **Inpatient Hospital Services.** Rendered at a licensed, accredited, Medicare qualified hospital, ambulatory surgery center or birthing center, including:

   a. Hospital room and board up to average hospital semiprivate room rates in the hospital's geographic area;

   b. Services in intensive care and other special units;

   c. Acute care and sub-acute care services;

   d. Other hospital services and supplies, including general nursing care; drugs and medications; anesthesia and oxygen; the administration of whole blood or blood plasma (but not the transfused substance); laboratory tests and services, and X-rays; and

   e. The Plan covers mastectomies and post mastectomy reconstructive procedures, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prosthesis and treatment of physical complications of mastectomy.

3. **Skilled Nursing Facility Confinements.** Covered Services include room and board charges (not in excess of 60 days per calendar year) up to average area semiprivate room and board rates in the facility's area, and other related nursing services and supplies rendered by a licensed, physician-supervised, Medicare qualified skilled nursing facility. Services are covered only if:

   a. The Member is confined to bed in the facility;

   b. The confinement immediately follows a hospital confinement or a period of home health care utilization for at least five (5) consecutive days;

   c. The Member's physician certifies that the confinement is needed for further care of the condition that caused the hospital or home health care confinement; and

   d. The Member's physician promptly completes and provides to the Plan Administrator an acceptable treatment plan which includes diagnosis, proposed course of treatment and expected discharge date.

4. **Outpatient Surgery and Services.** Covered Services include scheduled outpatient surgery, observation room care or other pre-approved outpatient treatment in a licensed hospital or other medical care facility; and related services and supplies, including, but not limited to, drugs and medications; anesthesia and oxygen; the administration of whole blood or blood plasma (but not the transfused substance); pre-operative laboratory tests and X-rays; and use of operating and recovery rooms.

5. **Family Planning and Pregnancy Related Services.** The following family planning and pregnancy related services are Covered Services when provided to a Member who is either an Eligible Employee or an Eligible Employee's spouse. Family planning and pregnancy related
services for Children are not covered, when the Member has reached their twenty-first (21st) birthday.

a. **Family Planning.** Covered Services include oral contraceptives and other approved contraceptive medications and devices. Approved prior authorized Sterilization procedures performed in an appropriate medical setting are also Covered Services.

b. **Abortion Services.** Covered Services include medically necessary abortion services. Abortion related services for Children are not covered, when the member has reached their twenty-first (21st) birthday.

c. **Maternity and Childbirth.** Covered Services include obstetrical, prenatal and post-natal care and all related inpatient hospital or birthing center services including nursery and newborn care until the mother's discharge. Pregnancy related services for Children are not covered, when the Member has reached their twenty-first (21st) birthday.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for a prescribing length of stay not in excess of 48 hours (or 96 hours).

6. **Diagnostic, Laboratory and X-ray Services.** Covered Services include charges for outpatient diagnostic laboratory tests performed in a physician's office or independent laboratory, or those laboratory services performed by a hospital or other medical care facility on an outpatient basis. Covered Services also include diagnostic X-rays, and radium and radioactive isotope therapy performed in a physician's office or diagnostic facility, or those performed by a hospital or other covered facility on an outpatient basis.

7. **Anesthesia Services.** Covered Services include general, regional or local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services.

8. **Orthopedic Devices and Prosthetic Appliances.** Covered Services include: (a) the initial purchase of artificial limbs and subsequent purchases due to physical growth for a continuously covered Member and (b) orthopedic devices such as customized braces, splints, and crutches when medically necessary. Benefits are payable only for orthopedic devices and prosthetic appliances required as a result of an injury or illness which occurred while the Member was covered under this Plan. No benefits are payable for services or supplies related to replacement of braces damaged or no longer functional due to willful destruction.

9. **Private Duty Nursing Care.** Covered Services include private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.), if:
a. The Member is confined to a hospital and the hospital's intensive care unit is full or the hospital has no intensive care unit; or  

b. The service is covered under home health care or skilled nursing facility services.

10. **Home Health Care.**  

a. The following home health care services are Covered Services if rendered:  

(1) By a licensed home health care agency approved by the Plan Administrator, for Home Health Care Visits and services furnished to a Member in his home;  

(2) Following inpatient hospital treatment or skilled nursing facility confinement or in place of hospitalization or a skilled nursing facility confinement (such as after outpatient surgery); and  

(3) In accordance with a home health care plan approved by the Plan Administrator under which such home health care services are expected to result in significant improvement of the Member's condition within a period of 90 days.  

b. Under home health care services, surgical dressings, medical appliances, and supplies which are medically necessary for treatment of the Member at home are covered, but only to the extent such items or services would have been covered under the Plan if the Member had been confined in a hospital or skilled nursing facility.  

c. "Home Health Care Visit" means: (1) each visit by a Licensed or Registered nurse to provide nursing care; (2) each visit by a licensed therapist to provide physical, occupational, or speech therapy, or cardiac rehabilitation; and (3) four hours of home health aide services. The maximum number of Home Health Care visits for which benefits are payable per calendar year, per Member, is 40.  

d. Covered Home Health Care services do not include services or supplies which are not specified in the applicable home health care plan, services of any social worker, custodial care, or transportation services.  

11. **Hospice Care Services and Supplies.** Covered Services include hospice care services and supplies where the Member's attending physician has diagnosed the Member as terminally ill, determined that the Member is expected to die within six months, and placed the Member under a hospice care plan approved by the Plan Administrator. Covered hospice care services and supplies are limited to $150 per day.  

12. **Physical, Speech, and Occupational Therapy, and Cardiac Rehabilitation.**  

a. Covered Services include physical, speech and occupational therapy services and related supplies for the Member subject to the following rules. Therapy will be covered only to the extent of restoration to the Member's level of pre-trauma, pre-illness, or pre-condition speech function. No therapy services are Covered Services to the extent they relate to dysfunctions, illnesses or injuries that arose before the Member began coverage under the Plan.
b. Therapy Services are covered only if ordered by a physician and performed by a licensed or certified physical, speech or occupational therapist. To be covered, therapy must be provided in accordance with a specific written treatment plan prepared by a physician which details the treatment to be rendered (including its frequency and duration), provides for on-going reviews, and only allows renewal of the treatment plan if the therapy remains medically necessary.

c. In addition to the other exclusions within this Plan, no benefits are payable for:
   (1) inpatient admission for therapy services except if continuation of an approved inpatient stay;
   (2) any therapy services or supplies, unless provided in accordance with a specific treatment plan, as described above;
   (3) therapy for academic underachievement, non-pervasive learning and delayed development disorders or abnormal speech pathology and communication disorders such as stuttering and stammering;
   (4) therapy which is primarily recreational or educational in nature, or special education, or lessons in sign language to instruct a Member whose ability to speak or hear has been lost or impaired, to function with that ability; and (5) maintenance therapy.

d. Speech Therapy is covered only if it follows an injury or illness other than a mental or nervous disorder.

e. Cardiac Rehabilitation is a Covered Service if rendered under physician supervision in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery and if the rehabilitation is initiated within 12 weeks of the onset of the medical condition or surgery and performed in a medical care facility.

13. **Durable Medical Equipment.** The Plan will provide benefits in connection with the rental or purchase by the Member of durable medical equipment provided that such rental or purchase over $500 is authorized and arranged for in advance by the Plan Administrator through its designated durable medical equipment provider. It is the Member's responsibility to make sure that the advance certification process is initiated and completed before purchasing or renting the equipment. Equipment must be determined to be medically necessary by the Plan Administrator to be covered.

14. **Contact Lenses/Glasses.** Covered Services include either initial glasses or contact lenses, but only following cataract surgery in which case the Plan will be secondary to any vision care insurance plan in which the Member participates.

15. **Hearing Care.** Covered Services include medically appropriate hearing aids/implants and the exams for their fitting with approved prior authorization up to a maximum of $1,500 per ear, every five years.

16. **Transplant Surgery.** Transplant surgery is a Covered Service as follows:

   a. Benefits are payable for human organ and tissue transplants, provided they are medically necessary, non-experimental, and meet other Plan criteria.

   b. No benefits are payable for any transplant or related expenses in which the Member is the donor unless services are through a Center of Excellence provider.
c. No benefits are payable for the cost of obtaining, evaluating or transporting the transplanted organ unless services are through a Center of Excellence provider.

d. No benefits are payable for non-human organ transplants or complications of non-human organ transplants.

17. **Obesity Treatment.** Bariatric surgery is a Covered Service as follows:

   a. Benefits are payable for one (1) Bariatric surgery per lifetime, provided it is medically necessary, non-experimental, and meets other Plan criteria.

   b. Care and treatment is provided by a multidisciplinary program experienced in obesity surgery that provides all of the following: (1) medical consultation with surgeons experienced with the procedure; (2) psychiatric consultation for evaluation; (3) nutritional counseling; (4) exercise counseling; (5) behavior modification; (6) clearance for surgery; and (7) support group meetings.

   c. No benefits are payable for any Bariatric surgery or related expenses unless services are through a Center of Excellence provider.

   d. In addition to the other exclusions within this Plan, no benefits are payable for Bariatric surgery unless: (1) you are morbidly obese and have been for five years or more despite attempted weight loss. Morbidly obese is defined as a Body Mass Index (BMI) of 40 or greater; (2) You are severely obese and have been for five years or more despite attempted weight loss and have a medical condition of type 2 diabetes, sleep apnea, heart disease, or hypertension. Severe obesity is defined as a Body Mass Index (BMI) of 35 or greater and must include at least one of these medical conditions listed; (3) You are 21 years of age or older; and (4) You have documentation of participation for six continuous months in a structured weight loss program that was supervised by your physician within the previous two years.

18. **Dialysis Treatments.** Covered Services include up to nine months of dialysis treatment and services related to dialysis treatments (including hemodialysis and peritoneal dialysis) for the treatment of severe kidney failure, chronic poor functioning of the kidneys or end stage renal disease.

19. **Emergency Services.** Covered Services include true emergencies defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in – (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part and requires the Member to seek immediate medical attention. Covered Services include but are not limited to physician treatment, hospital charges, drugs and medications, laboratory tests, and X-rays.

The Plan will not cover Hospital Emergency Room Facility Fees unless a true emergency exists.
20. **Ambulance Services.** Covered when provided by an agency authorized to provide such service to transport a Member in a land or air vehicle staffed by medically trained personnel and equipped to handle a medical emergency. Ambulance service is covered to the nearest hospital or skilled nursing facility where treatment can be furnished. Not covered are any charges made to transport the person: (1) if ambulance service is not required by the person's physical condition; (2) in any other vehicle; (3) to any other place; or (4) absent approval from the Plan Administrator more than 50 miles. Ambulance transportation from hospital to hospital is covered only when medically necessary.

21. **Spinal Manipulation/Chiropractic Services.** Covered Services include spinal manipulation and other chiropractic care by a licensed chiropractor. The covered expenses for such services are limited to the lesser of $25 per visit or 50% of the expense billed if services are provided by a Network Provider or provided by a Non-Network Provider if the Member's primary residence is outside the Network Service Area at the time in question. There is no coverage if such services are provided by a Non-Network Provider where the Member's primary residence is within the Network Service Area. The coverage for these services is limited to 18 visits per plan year.

22. **Dental Care.** Services and supplies for care of the mouth, teeth, gums and alveolar processes will be Covered Services only if that care is for the following oral surgical procedures:

   a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

   b. Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident and the accident must have occurred while the person was covered under the Plan.

   c. Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth if the Injuries occurred while covered under the Plan.

   d. External incision and drainage of cellulitis.

   e. Incision of sensory sinuses, salivary glands or ducts.

   f. Removal of full bony impacted wisdom teeth.

Note that the Plan's coverage of Dental Care will be secondary to any dental insurance plan in which the Member participates.

23. **Psychiatric Care.** Covered Services include Psychiatric Care Services for the treatment of Mental Disorders, Mental Illness and Substance Abuse. Care and services for the treatment of Impulse Control Disorders are not covered.

24. **Other Programs.** Certain disease management or wellness programs may be offered in addition to the Plan that may cover services and have payment provisions beyond the breadth and scope of the Plan. These programs are outside the Plan guidelines and may have special
elgibility and enrollment criteria. If you have any questions regarding these Programs, you should contact the Plan Administrator for assistance by calling toll free at 1-800-809-5916.

NETWORK PROVIDERS, ANNUAL DEDUCTIBLES, COPAYMENTS, PRE-EXISTING CONDITIONS AND OTHER LIMITATIONS

Network Providers

Certain hospitals and other health care providers have entered into agreements with Smithfield to provide health care services to Members at agreed-upon, preferred rates. Those hospitals and other health care providers are referred to as "Network Providers." Health care providers that have not entered into such comprehensive agreements with Smithfield are referred to as "Non-Network Providers." Generally, the Plan will pay a greater percentage of your cost for Covered Services if those Covered Services are received from a Network Provider. Nevertheless, each Member can and should use the health care provider of the Member's own choosing based on the Member's own needs and preferences. Neither Smithfield nor the Plan endorse, supervise or control any health care provider.

The Provider Network as of January 1, 2013 is identified on Schedule B attached to this document. A comprehensive directory of all Network Providers is available on the Anthem BCBS website at www.anthem.com. BCBS reserves the right to add and delete Network Providers, and otherwise modify the list of Network Providers, at any time. If you have any questions as to whether a particular health care provider is a Network Provider, you should contact the Plan Administrator for assistance by calling toll free at 1-800-809-5916.

Annual Network Deductible

In the case of services provided by Network Providers during a Plan year, the Plan requires you to pay an Annual Network Deductible. The Annual Network Deductible is the cost of Covered Services you must pay each calendar year before the Plan starts to pay benefits. The amount of Annual Network Deductible is $250 per Member per Plan Year. In the case of Members with "Employee and Dependent(s)" coverage or "Family" coverage (i.e., both the Member and one or more of his Dependents are enrolled), the Annual Network Deductible will not apply to any of the family Members for the Plan year once at least two of them have paid the Annual Network Deductible for the year. In order that an Annual Network Deductible not be applied late in one year and soon after in the following year, the Program contains a carryover provision. This means that any covered expenses you have incurred in the last quarter of the Plan year which apply toward the Annual Network Deductible will also be applied toward the Annual Network Deductible for the following calendar year.

The Annual Network Deductible does not include amounts you pay for services that are not covered, not subject to the deductible, expenses above the "usual and reasonable" limit, penalties and amounts you paid for charges incurred prior to a previous lapse in coverage if you subsequently regain coverage.
Non-Network Deductible

In the case of services provided by Non-Network Providers, the Plan requires you to pay an Annual Non-Network Deductible. The Annual Non-Network Deductible is the cost of Covered Services you must pay each calendar year before the Plan starts to pay benefits. No benefits are available for any services rendered by Non-Network Providers except that the Deductible is $250 per Member per Plan Year when applied to Covered Services that the Plan Administrator determines not to be available from any appropriate Network Provider located within 50 miles of the Member's primary residence, or to be true Emergency Services provided by a Non-Network Provider that is nearer to the location of the Member than any appropriate Network Provider. In the case of Members with "Employee and Dependent(s)" coverage or "Family" coverage (i.e., both the Member and one or more of his Dependents are enrolled), the Annual Non-Network Deductible will not apply to any of the Family members for the Plan Year once at least two of them have paid the Deductible for the year ($500 or if applicable, $250 each). The Annual Non-Network Deductible does not contain a carryover provision. This means that any covered services incurred with a Non-Network Provider in the last quarter of the Plan year which apply toward the Annual Non-Network Deductible will not be credited toward the Non-Network Deductible for the following calendar year.

The Annual Non-Network Deductible does not include Copayments, amounts you pay for services that are not covered, not subject to the deductible, expenses above the "usual and reasonable" limit, penalties and amounts you paid for charges incurred prior to a previous lapse in coverage if you subsequently regain coverage.

Copayments

The Copayment is the percentage and/or amount of the usual and customary covered charge that you must pay for Covered Services after you have met any applicable annual deductibles. The various Copayments for Covered Services under the Plan vary based on whether the provider rendering those services is a Network Provider or a Non-Network Provider, the identity of the provider (if they are a Network Provider), the nature of the services rendered, and other factors.

Services Provided Outside of the United States

If you are traveling outside the United States and are in need of medical attention, coverage will be provided only as follows: outpatient emergency services will be processed subject to Plan deductibles and copayments as services provided by Non-Network Providers. The claim will be paid upfront by you and you can then file a claim with BCBS on an itemized bill. There is also a Bluecard WorldWide Network for inpatient services but not outpatient. If the facility that provides services to you is in the Bluecard WorldWide Network, the inpatient facility claim will pay at the Network Provider rate subject to applicable Plan deductibles and copayments. The Bluecard WorldWide Network hospitals are located in many major cities in Europe and Asia. Additional information about this program may be found at http://www.bluecardworldwide.com.

The listing of the applicable Copayments for Covered Services is set forth in Schedule D attached to this summary. Smithfield reserves the right to change that schedule at any time.
Usual and Reasonable Expense Limitation

The Plan pays a percentage of all "usual and reasonable" covered charges after the Annual Deductible has been satisfied. No payments are made for charges in excess of the "usual and reasonable" fee limit.

Exclusions

The Plan does not cover or provide any benefits for custodial care, cosmetic surgery, occupational illness or injury, experimental or investigational services or the other items set forth on Schedule A attached hereto. Please review the list of excluded services (Schedule A) carefully and contact the Plan Administrator if you have any questions.

Medically Necessary Services

The Plan only pays or provides reimbursement for medically necessary services.

The Plan defines medically necessary as the services or supplies provided by a hospital, physician or other provider that are required to identify or treat your illness or injury (including pregnancy-related conditions) and which are consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury; appropriate with regard to and in accordance with standards of good medical practices; not solely for your convenience or for the convenience of a physician, hospital or other provider; and the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an inpatient, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an outpatient or at a lesser level of institutional care.

Pre-existing Conditions

The Plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before enrolling in the Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. A "pre-existing condition" means an illness, injury or condition for which medical advice, diagnosis, care or treatment was recommended or received during a six-month period. If a Member is subject to the Plan's four (4) month eligibility waiting period and enrolls timely after completing the waiting period, this six-month period ends on the day before the waiting period begins. Otherwise, this six-month period ends on the day before the Member's Plan coverage becomes effective. The pre-existing condition exclusion does not apply to your Children under age 19. In addition, the exclusion does not apply to pregnancy and pregnancy-related conditions.

The Plan generally will pay benefits for expenses resulting from or related to pre-existing conditions only if the expenses in question are incurred after the exclusion period described below.

If a Member is subject to the Plan's four (4) month eligibility waiting period and enrolls timely after completing the waiting period, the exclusion period is twelve (12) months from the first day
of the waiting period, reduced by the number of days of the Member's prior "creditable coverage," if any. Otherwise, the exclusion period is twelve (12) months (eighteen (18) months in the case of a late enrollee) from the Member's first day of Plan coverage, reduced by the number of days of prior "creditable coverage," if any.

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least sixty-three (63) days. To reduce the twelve-month (or eighteen-month) exclusion period by your creditable coverage, you should give the Plan Administrator a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, the Plan Administrator will help you obtain one from the prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to the Plan Administrator at 1-800-809-5916.

**UTILIZATION REVIEW (U.R. PROGRAM)**

In the case of surgery (inpatient and outpatient), pregnancy, hospital inpatient or nursing facility confinement, MRIs, PET scans, sleep disorders, and durable medical equipment purchases over $500, the amount the Plan will pay after the Annual Deductible and your Copayment will be reduced by $750 if you do not follow the Plan's U.R. certification review program. In the case of drugs or medicines (including injectables) other than for chemotherapy or dialysis treatment, the Plan will not pay any portion of the charges for the drugs or medicines or their administration if you do not follow the Plan's certification review program. Unless excused under the U.R. Program, an additional benefits reduction applies if you fail to obtain a second or third opinion as to the medical necessity of any scheduled surgery. The U.R. Program is designed to help the Plan determine whether or not services or treatments are medically necessary.

The U.R. Program is not designed to be a substitute for the medical judgment of your physician or other health care provider. The Plan does not practice medicine.

The U.R. Program is a utilization management program administered by Mid-Atlantic Health Solutions, (the "U.R. Administrator"). You can contact the U.R. Administrator 24 hours a day at 1-800-570-4888. The U.R. Program works as follows:

1. **Pretreatment Reviews.** Advance review is performed for all scheduled Hospital and Skilled Nursing confinements and scheduled surgeries (whether inpatient or outpatient), as well as MRIs, PET scans, sleep disorders, and any acquisition of Durable Medical Equipment over $500. In the case of drugs or medicines (including injectables) other than for chemotherapy or dialysis treatment, the Plan will not pay any portion of the charges for the drugs or medicines or their administration if you do not follow the Plan's certification review program. The Member or his physician must notify the U.R. Administrator at least one week prior to the scheduled confinement or surgery, request U.R. review, and provide such information as the U.R. Administrator requests. Following review and approval, a certification letter will be sent to the covered person, the attending physician and the hospital or other facility. If the Member does
not receive his/her certification letter at least four (4) business days before the scheduled admission, surgery or treatment he or she should call the U.R. Administrator to verify the certification will be sent to the facility, the Member and/or the attending physician.

2. **Concurrent Review and Discharge Planning.** Reviews are performed for hospital confinements after admission and during the confinement. Where necessary, arrangements are made to facilitate the Member's earliest possible discharge or completion of the Member's course of treatment.

3. **Emergency Admissions.** Retrospective review of all emergency admissions is also performed. For emergency service admissions, the Member or his family or Physician must notify the U.R. Administrator within 48 hours after the admission or the $750 benefits reduction will apply.

4. **Maternity and Childbirth.** Pretreatment Review (as described above) is required in the case of deliveries of pregnant Members. Pregnant Members are encouraged to contact the U.R. Administrator as soon as possible after confirmation of pregnancy to obtain initial certification. After receiving the initial call, the U.R. Administrator may contact the attending physician to discuss the pregnancy and to identify potential risk factors, if any, that could adversely affect the Member or unborn Child during the gestation period, at delivery and after birth. Note that pregnancy related services are provided only for Members who are Eligible Employees or spouses of Eligible Employees, and that pregnancy related services are not provided for Children, when the Member has reached their twenty-first (21st) birthday.

5. **Catastrophic Case Management.** Members with catastrophic diagnoses or multiple medical and socioeconomic needs are referred to case management to facilitate timely delivery of quality care in an efficient manner.

6. **Additional Hospitalization.** If the attending Physician feels, due to extenuating circumstances, that additional hospital days are needed to treat a condition properly, he or she may contact the U.R. Administrator to discuss the medical necessity and to request certification of the additional number of days or medical care. The U.R. Administrator must be contacted to obtain certification of all additional days of hospital confinement.

   *It is the Member's responsibility to make sure that the U.R. certification process is initiated and completed.*

7. **Second and Third Opinions.** In the case of any elective or other surgical procedure (other than emergency surgery), the amount the Plan will pay (after the Annual Deductible, the Non-Network Deductible, the applicable Copayment and any other U.R. benefits reduction) will be reduced by 50% unless the Member complies with the following requirements.

   Unless excused by the U.R. Administrator in writing at the time of certification under the U.R. Program, a Member seeking coverage for any surgery (other than emergency surgery) must consult with and obtain a second opinion from a qualified, independent physician regarding the need for the surgery. If such second opinion does not confirm the need for surgery, the Member must consult with and obtain a third opinion from a qualified, independent physician regarding
the need for the surgery. If the second and third opinion does not confirm the need for the surgery, the Member may still elect to have the surgery, but no Plan benefits will be paid unless the Administrator determines that the surgery was medically necessary. All second and third consultations and opinions hereunder must be performed by physicians who are board certified specialists in the medical practice area with respect to which the surgery relates and who are not financially associated with either the physician originally recommending the surgery (or, in the case of a third opinion, the physician who provides the second opinion) or the facility where it will be performed.

The Plan will pay 100% of the cost of obtaining, and the Member will not be charged the Annual Non-Network Deductible or any Copayment for, the second and third opinions required under the U.R. Program.

PRESCRIPTION DRUG BENEFITS

General

The Plan provides partial reimbursement for the cost of prescription drugs acquired during the Member's period of coverage under the Plan. Only prescriptions purchased from an approved pharmacy are covered. In order for prescription drugs purchased at an approved retail pharmacy to be covered, the Member must present his Plan I.D. card for reimbursement to take effect. The Plan will pay the balance of the cost of non-excluded generic drugs after the Member pays the applicable Copayment described below. If a Member purchases a brand name prescription drug rather than a generic drug, the Plan will pay an amount equal to the balance of the cost of the most comparable generic drug after the Member pays the brand name drug Copayment listed below; provided, however, that if the prescribing Physician directs the use of the brand name prescription drug and prescribes that the generic substitute not be used, the Plan's reimbursement will be based on the full cost of the brand name drug less the applicable Copayment. The covered drug charge for any one prescription is limited to a 30-day supply (up to a 90-day supply for mail order) plus refills up to the number of times specified by a physician if refilled within one year from the date of initial prescription.

Your pharmacy coverage includes a three-tier copayment benefit. This means that when you present your membership card at a participating retail pharmacy, you will be required to make one of the following copayments for your prescriptions based on the type of medication you purchase:

- For a generic drug on the formulary, you will make a 10% copayment per prescription for a maximum 30-day supply.
- For a premium brand drug on the formulary, when a generic equivalent is not available, you will make a 30% copayment per prescription (not to exceed a $200 per prescription copayment) for a maximum 30-day supply.
- For a brand-name drug on the formulary, you will make a 50% copayment per prescription (not to exceed a $200 per prescription copayment) for a maximum 30-day supply.
Note – the following section on Maintenance Drugs describes the Plan's requirement that maintenance drugs be filled through mail order instead of at a retail pharmacy (except for the first 30-day supply.)

**Maintenance Drugs by Mail Order**

Maintenance drugs are those medications that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc. Maintenance drugs must be purchased by mail order, except that the first 30-day supply may be purchased at an approved retail pharmacy. Because of volume buying, Catamaran Home Delivery, the mail order pharmacy, offers Members significant savings on their prescriptions. The cost per 90-day supply is a 10% copayment for generic drugs; 30% for premium brand drugs on the formulary (not to exceed a $600 per prescription copayment); and 50% for brand-name drugs on the formulary (not to exceed a $600 per prescription copayment). The mail order prescription address is:

Catamaran Home Delivery  
P. O. Box 407096  
Ft. Lauderdale, FL 33340-7096

**Covered Prescription Drugs**

Covered prescription drugs for which reimbursement is available are limited to a 30-day supply (90-day supply in the case of mail order) of the following items unless listed as excluded on Schedule A:

- Drugs prescribed by a physician that require a prescription either by federal or state law; and
- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

**COBRA CONTINUATION COVERAGE**

You and/or your spouse and/or other dependents who are covered under the Plan can elect to continue Plan medical and prescription drug coverage when certain "qualifying events" occur which would otherwise cause a loss of coverage.

Qualifying events include your:

- termination of employment with Smithfield (unless you are discharged for gross misconduct);
- reduction in your work hours;
- death;
- divorce or separation from a Member;
o Child ceasing to be a Child as defined in the plan; or

o entitlement to Medicare.

Both you and Smithfield have responsibilities when certain events occur which qualify you for continued coverage.

The Plan Administrator will notify you or your covered dependents of your right to elect continued coverage in the event of your:

o termination of employment;

o reduction in hours;

o your death; or

o your entitlement to Medicare.

You or your covered spouse or other dependent must notify Smithfield within sixty (60) days in the event of your divorce or marital separation or a Child's losing eligibility for coverage as a Child. You must provide this notice, in writing, to your Human Resource department or the Health Care & Benefits department of Smithfield Foods, Inc. (whose address is at the end of this booklet under "More Information about the Plan/Plan Administrator"). Smithfield will offer COBRA continuation coverage to qualified beneficiaries only after Smithfield has been notified a qualifying event has occurred. If you fail to notify Smithfield within sixty (60) days after such an event, you will forfeit your right to COBRA continuation coverage.

You and your covered dependents will have a 60-day period during which to choose continued coverage. The 60-day election period begins on the later of the date coverage terminates or the date of notification of the right to elect continued coverage. **Continuation coverage may not be elected after expiration of the 60-day election period.** You are required to pay 102% of the full cost of continued coverage (both employee and employer share) of continued coverage elected. If you elect to extend the COBRA period from 18 to 29 months on account of Social Security for disability as described below, you must pay 150% of the full cost of continuing coverage. Your first payment must begin no later than 45 days after the date you elect continued coverage and will be retroactive to the date you lost coverage. Thereafter, you must pay for the coverage in monthly installments.

If you and/or your covered spouse and/or dependents choose continued coverage, coverage will begin on the date of the qualifying event. Initially, you and/or your covered spouse and/or dependents will be entitled to the same coverage you had the day before the qualifying event (you may not add dependents as part of a COBRA election). Thereafter, you will be entitled to the same coverage (and opportunities to change coverage) that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Prospective changes in the Plan will apply to you in the same way they apply to active employees. If you do not choose continued coverage, your health coverage will end on the date of the qualifying event. No conversion to an individual health insurance policy is available since the Plan is self-insured.
In general, coverage may be continued for up to a total of 18 months after the date of the qualifying event in the case of termination or reduction of hours, and for up to a total of 36 months in the case of other qualifying events.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, and you notify your group health plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To extend the period of coverage due to disability, you must notify Smithfield within 60 days after the later of (1) the date of the disability determination by the Social Security Administration and (2) the date the qualifying event occurs, and in no event later than the end of the initial 18-month period of continuation coverage. You must provide this notice, in writing, to your Human Resource department or Health Care & Benefits department of Smithfield Foods, Inc. (whose address is at the end of this Notice under "More Information About the Plan/Plan Administrator").

If you are entitled to receive 18 months of COBRA continuation coverage because your spouse or parent terminated employment or reduced hours of employment, and your spouse or parent becomes covered by Medicare, you may be able to extend the maximum period of COBRA continuation coverage for yourself from 18 months to a maximum of 36 months.

If you are covered by both Medicare and the Smithfield Plan before a qualifying event occurs, then you may have the right to elect COBRA continuation coverage with respect to your Plan coverage for the maximum period of coverage available. Becoming covered by Medicare at any time after election of COBRA continuation coverage will generally cause your COBRA continuation coverage to end. However, if you are the covered employee, and your COBRA continuation coverage ends because you become covered by Medicare, then the COBRA continuation coverage of your family members may be extended as mentioned above.

COBRA continuation coverage will end before the end of the maximum coverage period if:

1. Smithfield Foods, Inc. and its subsidiaries cease to maintain any group health plan for any of their employees;

2. Any required premium for continuation coverage is not paid in a timely manner;

3. After electing continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of that qualified beneficiary;

4. After electing continuation coverage, a qualified beneficiary enrolls in and becomes covered by Medicare; or

5. A final Social Security determination is made that a qualified beneficiary receiving extended continuation coverage due to disability is no longer disabled.

You must notify the Plan Administrator upon the occurrence of the last two events listed above.
SHORT-TERM DISABILITY BENEFIT FOR EMPLOYEE MEMBERS

General

The Plan provides a short-term disability benefit to eligible employee Members who become totally disabled. Members covered as dependents receive no disability benefits.

The weekly short-term disability benefit is $130.00 per week. For periods of total disability of less than a full seven day week, the disability benefit is pro rated on a daily basis, based on a seven day week.

Determination of Disability

Total disability means you are: (a) unable to perform the customary duties of your regular job with Smithfield or any other job for which your education, training and experience qualify you; (b) under the regular care of a licensed physician (other than a chiropractor); and (c) not gainfully employed in any other occupation.

Commencement of Benefit

If you become totally disabled as a result of an injury, your disability benefit will commence on the date you first become totally disabled. If you become totally disabled as a result of an illness, the disability benefit will commence on the eighth day of your total disability.

Benefit Duration

Short-term disability benefits are payable until the earlier of: (a) the expiration of 13 weeks of benefits; (b) you are no longer totally disabled (either because you are again capable of work or you cease to be under the regular care of a physician); (c) your death or termination of employment; or (d) your failure to provide adequate verification of your disability. Successive periods of total disability will be considered as one period of disability for purposes of determining the duration of benefits if they arise from the same or related causes and are separated by less than two weeks of continuous active employment with the employer or if they arise from different and unrelated causes and are not separated by a return to active employment with Smithfield.

Exclusions

No disability benefits are payable for disabilities arising from intentionally self-inflicted injuries (while competent) or self-inflicted injuries while permanently or temporarily incompetent, from participation in the commission of a criminal act, arising out of war or acts of insurrection or civil disturbance, from illegal use of alcohol or controlled substances, or from driving under the influence of alcohol or controlled substances. Additionally, no disability benefits are payable for occupational injury or sickness (injury or sickness arising out of employment or other work for wages or profit) or for which workers’ compensation benefits are payable.
**Verification of Disability**

To receive disability benefits, you must provide the Plan Administrator with a statement signed by your physician (other than a chiropractor) setting forth the nature of the disability, its cause and expected duration, your symptoms, the date the injury or illness triggering the disability occurred, the physician’s diagnosis, the dates and nature of treatments rendered and the progress you have made towards recovery. This statement must be received by the Plan Administrator within ninety (90) days after the date your disability began.

The physician’s statement must also include information regarding your suitability for rehabilitation. The Plan Administrator may also require you to submit to one or more examinations by a second physician appointed by the Plan Administrator. Failure to submit to such examination(s) will result in termination of benefits.

**Offset**

The amount of total disability benefit payable will be reduced by any benefits which you receive or are entitled to receive from any federal disability insurance trust, under the Social Security system or from the Veterans Administration, from any other governmental agency or fund or any other arrangement pursuant to any compulsory act or law.

**PLAN COORDINATION OF BENEFITS**

The Plan helps pay your medical bills. It is intended to provide you with specific levels of benefits. If you or your covered dependents are eligible to receive benefits under other plans, benefits under the Plan may be reduced.

"Other Plans" include any governmental or private sector insured or uninsured plans or programs providing group or individual medical benefits or services.

Benefits are coordinated so that the benefits paid by the Plan, plus the benefits under your other coverage, will not exceed the amount that the Plan would pay in the absence of the other coverage. To be eligible for Plan benefits, you must provide information and cooperate with the Plan Administrator so that your Plan benefits can be coordinated with other benefit coverages that you and your dependents have.

Benefits are coordinated during each calendar year. In coordinating benefits, one of the plans is the Primary Plan. It pays first. Each remaining plan is a Secondary Plan. The Primary Plan pays without regard to the other plans. The amount of benefits, if any, payable under a Secondary Plan is determined after taking into account the amount of benefits payable under the Primary Plan. If this Plan is the Secondary Plan, the benefits payable under this Plan will be reduced so that the total amounts payable under the Primary Plan and this Plan do not exceed the covered charges that this Plan would pay in the absence of the other coverage.
In determining the order of payment, any Other Plan without a coordination provision, auto insurance plan or policy, or other personal liability insurance plan or policy is the Primary Plan and always pays first. If the Other Plan automatically provides that it pays first, it is the Primary Plan. If all Other Plans have coordination provisions, the following rules determine the order of payment.

- A plan is the Primary Plan if it covers the patient as an employee (versus dependent).
- If both plans cover the patient as an employee, the Primary Plan is the one that covers the patient as an employee through present employment. A plan is secondary if it covers the patient as a former employee.
- A Plan is secondary if it covers the patient as a former employee. For this reason, upon your termination of employment, Medicare becomes your primary coverage, with COBRA acting as your secondary coverage, and the two will coordinate benefits on your behalf.
- A plan is secondary if it covers the patient as a dependent. If both plans cover the patient as a dependent, the Primary Plan generally is the one that covers the patient as a dependent of a person whose birthday occurs earliest in the calendar year.
- If the patient is a Child of divorced or legally separated parents, the Primary Plan will be determined in the following order, unless a court order states otherwise:
  1. the plan of the parent with custody;
  2. the plan of the spouse of the parent with custody;
  3. the plan of the parent without custody; and
  4. the plan of the spouse of the parent without custody.
- If none of the above rules apply, the plan which has covered the patient the longest is the Primary Plan.

When you file a claim, you must give information about any other coverage you have. The Plan Administrator or any other designated claims processor can release information to, or get information from, any source to apply the coordination of benefits provision. If the Plan pays too much, the excess can be recovered from the payee, you or another organization providing coverage.

**RIGHT TO SUBROGATION, REIMBURSEMENT, AND INTERVENTION**

When the Plan pays a claim for benefits, the Plan has the right of subrogation. Subrogation is the right of recovery against any third party or insurer who might be liable for the injury or illness for which benefits are payable. Similarly, the Plan has the right to be reimbursed by you or your dependents out of any payment you receive from such a third party. The Plan may also intervene in any lawsuit you bring against a third party or insurer. You agree to cooperate with the Plan to
assist it in pursuing its right to subrogation, reimbursement, and intervention, including attendance at trials, depositions, and meetings with the Plan's counsel.

If you or a covered dependent are involved in an automobile accident or in any situation where the Plan's right to subrogation and reimbursement may be applicable, the Plan Administrator will require you or your dependents (depending on their age) and your or your dependent’s attorney to complete and sign an Accidental Injury Report, a Subrogation and Reimbursement Acknowledgment Statement and a Subrogation Statement. Before the Plan will pay any claims related to any accident, and no later than 30 days following the accident, you must complete an Accidental Injury Report, including a signed Subrogation and Reimbursement Acknowledgment Statement, and submit it to the Company. If you do not fully and truthfully complete the Accidental Injury Report and Subrogation and Reimbursement Acknowledgement Statement, you and your dependents will not be permitted to continue to participate in the Plan, and the Plan will not pay any future claims for benefits for this accident or any other medical condition.

If you are requested to complete a Subrogation Statement, then you must complete and return the Subrogation Statement to the Plan within the period indicated by the Plan or the Plan may cease payment of claims for benefits relating to the accident. If you or your attorney or agent does not comply in full with the Plan's subrogation rights, you and your dependents will not be permitted to continue to participate in the Plan, and the Plan will not pay any future claims for benefits for this accident or any other medical condition.

If you are in an accident and do not timely complete an Accidental Injury Report, including a signed Subrogation and Reimbursement Acknowledgment Statement, when requested, but the Plan pays benefits related to the accident, then you must reimburse the Plan for any and all monies received for any injury or illness related to the accident.

It is the responsibility of you and your dependents to reimburse the Plan for any and all monies received from a third party who may be liable for you or your covered dependent's injury or illness up to the amount of the benefits payable under the Plan and any costs of collection incurred by the Plan. You and your dependents must also cooperate with the Plan to insure that the Plan can properly pursue its subrogation, reimbursement and intervention rights.

By enrolling in the Plan you consent to the Plan's subrogation, reimbursement and intervention rights, agree that the Plan can pursue any claim that you may have against a third party or insurer to recover benefits paid under the Plan, that the Plan may intervene in any lawsuit you bring for your injuries, and grant the Plan a lien on any and all amounts you may recover from such third party or insurer (without reduction for attorneys' fees).

If you receive payments for future related medical claims, the Plan will deny payment of any related future benefits so as to prevent a double recovery as specified under the coordination of benefits Article of the Plan. As discussed in the previous Section entitled, "Plan Coordination of Benefits," the Plan will not pay benefits until any Other Plan without a coordination provision, auto insurance plan or policy, or other personal liability insurance plan or policy has paid first.
If benefits under the Plan are overpaid for any reason, the Plan may recover from the applicable Eligible Employee and/or his dependent the amount overpaid and may institute suit to recover any such overpayment.

The Plan hereby disavows the application of any common law equitable principles such as the “make whole” rule or the “common fund” doctrine, which shall not be applied to reduce the Plan’s rights of subrogation, reimbursement or intervention in any case. Moreover, the Plan shall have absolute first priority to any funds recovered from any third party or insurer, as well as an absolute right to any full or partial recovery (regardless of whether you and/or your covered dependents have been fully compensated for you and/or your covered dependent’s injury or illness).

TERMINATION OR AMENDMENT OF THE PLAN

Smithfield, by action of its duly authorized corporate officer, may terminate or amend the Plan in any manner at any time without notice to or the consent of any other person. No Member shall have any vested right to benefits under the Plan.

CLAIMS PROCEDURES

How To File Claims and Requests for Certification

The Plan Administrator processes claims under the Plan and has full discretion to review and resolve all claims. You or your provider must submit a claim for payment on such form as the Plan Administrator directs.

Claims should be filed within 30 days of the covered service. In no event may a claim be filed later than 1 year after the date the services were obtained. Late filed claims will be invalid and denied.

If the Plan Administrator requests additional information regarding your claim, that additional information must be supplied within 90 days of the Plan Administrator's first written request for the additional information or your claims will be denied.

If advance review or certification is required under the U.R. Program for a service, care, treatment, or supply, you must submit your request for certification to the U.R. Administrator. See the Utilization Review (U.R. Program) section of this document. Any service, care, treatment, or supply for which the U.R. Administrator makes a certification determination remains subject to review and approval or denial by the Plan pursuant to the process for Post-Service claims and appeals described below.

Requests for certification must be submitted to the U.R. Administrator at least one week before such service, care, treatment, or supply is to be provided, whenever possible, and in no event may a request for certification be filed after the provision of service, care, treatment, or supply. Late filed requests for certification will be invalid and denied.
You may file claims for Plan benefits or requests for certification either yourself or through an authorized representative. An "authorized representative" generally means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims or requests for certification on your behalf. In the case of an Urgent Certification Request (described in Section 2 below) or a Certification Request determination, which is urgent at the time of appeal (described in Section 1 below relating to Expedited Appeals), a health care professional with knowledge of your condition may always act as your authorized representative.

You must cooperate with and assist the Plan Administrator and the U.R. Administrator in processing your claim or request for certification, including, but not limited to, furnishing any documentation or making yourself available to be interviewed by appropriate representatives of the Plan.

**Initial Determinations**

1. **Emergency Services.** "True Emergency Services" means true emergency services provided when a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part and requires the Member to seek immediate medical attention.

   **Services provided in an emergency room are not necessarily covered Emergency Services.**

A Member, his physician, or a family representative must contact the U.R. Administrator within 48 hours, or as soon thereafter as possible, after the Member receives Extensive Emergency Services, and such contact is a Retrospective Review Notification. Extensive Emergency Services are Emergency Services that require a Hospital or Skilled Nursing Facility confinement, inpatient or outpatient surgery, an MRI, PET scan, treatment of a sleep disorder, or Durable Medical Equipment over $500. In the case of drugs or medicines (including injectables) other than for chemotherapy or dialysis treatment, the Plan will not pay any portion of the charges for the drugs or medicines or their administration if you do not follow the Plan's certification review program. Extensive Emergency Services require Certification, as defined below. Retrospective review of Extensive Emergency Services is performed pursuant to the U.R. Program, and all such reviews are processed in accordance with the procedures relating to Post-Service Claims described in Section 4 below.

Standard Emergency Services are Emergency Services that do not require a Hospital or Skilled Nursing Facility confinement, inpatient or outpatient surgery, an MRI, PET scan, treatment of a sleep disorder, or Durable Medical Equipment over $500. Standard Emergency Services are treated as Post-Service Claims, but they are not subject to Retrospective Review and Certification, as defined below, under the U.R. Program. In the case of drugs or medicines (including injectables) other than for chemotherapy or dialysis treatment, the Plan will not pay
any portion of the charges for the drugs or medicines or their administration if you do not follow the Plan's certification review program.

2. **Urgent Certification Requests.** "Certification" means the U.R. Administrator's review and confirmation of the Medical Necessity of any service, care, treatment, or supply as described in the Utilization Review (U.R. Program) section of this document. "Certification Request" means a request for such Certification.

"Urgent Certification Request" means any Certification Request which seeks Certification of a service, care, treatment, or supply with respect to which both: 1) the application of the usual time periods for determining Standard Certification Requests (described in Section 3 below) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Certification Request, and 2) advance Certification is required in order to avoid benefit reduction.

If the Plan requires advance Certification of a service, supply or procedure in order to avoid benefit reduction and if you or your representative makes a Certification Request, the U.R. Administrator will decide your request. If the U.R. Administrator or your physician determines that the request is an Urgent Certification Request, you will be notified of the Certification determination as soon as possible, taking into account the urgency of the medical circumstances, but not later than 72 hours after the Certification Request is received.

If there is not sufficient information to decide whether, or to what extent the Urgent Certification Request satisfies the U.R. Certification criteria, the U.R. Administrator will notify you of the information necessary to complete the Certification determination as soon as possible, but not later than 24 hours after receipt of the Urgent Certification Request. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and the U.R. Administrator will notify you of the determination not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier). If you do not furnish the requested information within that additional period, your Urgent Certification Request will be denied.

For Urgent Certification Requests which name a specific claimant, medical condition, and service or supply for which Certification is requested, and which are submitted to the U.R. Administrator, but which otherwise fail to follow the Plan's procedures for making Urgent Certification Requests, you will be notified of the failure within 24 hours and of the proper procedures to be followed. The notice may be oral unless you request written notification.

3. **Standard Certification Requests.** As described above, a "Certification" is a review and confirmation by the U.R. Administrator of the Medical Necessity of any service, care, treatment, or supply as described in the Utilization Review (U.R. Program) section of this document, and a "Certification Request" is a request for such Certification. A "Standard Certification Request" is any Certification Request which is not an Urgent Certification Request and which seeks Certification of a service, care, treatment, or supply for which the Plan requires advance Certification in order to avoid benefit reduction.
If you make a Standard Certification Request, the U.R. Administrator will notify you of the Certification determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the Standard Certification Request.

This time period may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15-day period. For example, the time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the U.R. Administrator's determination on your Standard Certification Request no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). If you do not furnish the requested information within that additional period, your Certification Request will be denied.

For Standard Certification Requests which name a specific claimant, medical condition, and service or supply for which Certification is requested, and which are submitted to the U.R. Administrator, but which otherwise fail to follow the Plan's procedures for making Standard Certification Requests, you will be notified of the failure within 5 days and of the proper procedures to be followed. The notice may be oral unless you request written notification.

4. Post-Service Claims. A Post-Service Claim is any claim which is not an Urgent Certification Request or Standard Certification Request. In the case of a Post-Service Claim, including Emergency Services, the Plan will notify you of the determination within a reasonable period of time, but not later than 30 days after receipt of the claim. Retrospective review of Extensive Emergency Services is also handled in accordance with these Post-Service Claim procedures. In the case of Extensive Emergency Services, the U.R. Administrator will notify you of its certification determination within a reasonable period of time, but not later than 30 days after receipt of the Retrospective Review Notification.

These time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 30-day period. For example, the time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will then be notified of the determination no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). If you do not furnish the requested information within that additional period, your claim will be denied.

5. Ongoing Course of Treatment. The U.R. Administrator engages in Concurrent Reviews, which are reviews of all hospital confinements after admission and during the confinement, pursuant to the U.R. Program. The U.R. Administrator also engages in Discharge Planning pursuant to the U.R. Program, and where necessary, arrangements are made to facilitate the Member's earliest possible discharge or completion of the Member's course of treatment.

If you are receiving an ongoing course of treatment, the U.R. Administrator will notify you in advance of any determination to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the determination before the termination or reduction
takes effect. The 180-day period for submission of appeals (described in the Appeal Rights for Adverse Benefit Determinations section below) does not apply to appeals relating to a termination or reduction of benefits received in an ongoing course of treatment. Rather, such appeals must be submitted within a reasonable period of time, which shall not unreasonably exceed the time by which the termination or reduction is to take effect.

An ongoing course of treatment may be urgent, (that is, it may relate to medical care or treatment with respect to which the application of the usual time periods for making a benefit determination could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition would subject to the Member to severe pain that cannot be adequately managed without the care or treatment). If an ongoing course of treatment involves such an urgent situation, and you request an extension of the course of treatment at least 24 hours before its expiration, the U.R. Administrator will notify you of the determination within 24 hours after receipt of the request.

5. **Manner and Content of Notification.** For Post-Service Claims, including Standard Emergency Services, the Plan Administrator will provide you with written notification of its determination as to any such claim you make. The U.R. Administrator will provide you with written notification of its determination as to any Certification, Concurrent Review, Discharge Plan, or Retrospective Review of Extensive Emergency Services. If the Plan denies a benefit or reduces, terminates, or fails to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in the Plan, or if the U.R. Administrator denies Certification of a service, care, treatment, or supply, the decision is an "adverse benefit determination." In the case of an adverse benefit determination, the notification to you will include the following: 1) The specific reason(s) for the determination; and 2) Reference to the specific Plan provisions on which the determination is based; and 3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why the material or information is necessary; and 4) Information as to the steps to be taken if you wish to submit the claim for review, including the time limits; and 5) A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), following an adverse benefit determination on review; and 6) If an internal rule, guideline, protocol, or other similar criterion (a "criterion") was relied upon in making the determination, either the specific criterion or a statement that such a criterion was relied upon in making the determination and that a copy of it will be provided free of charge to you upon request; and 7) If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination is based, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon your request. If the adverse benefit determination involves an Urgent Certification Request, this information may be provided to you first orally and then in writing within 3 days after the oral notification. The written notification of the determination of an Urgent Certification Request will include a description of the expedited review process applicable to such Certification Request.
No lawsuit relating to any claim for benefits, Certification Request, or benefit or Certification determination may be filed in any state or Federal court by any claimant unless and until the claimant has duly filed the claim or Certification Request in accordance with the process described in this section, has also duly appealed the determination of the claim, Certification Request, or other matter in accordance with the following section describing Appeal Rights for Adverse Benefit Determinations and has also received an adverse determination on review.

**APPEAL RIGHTS**

**Appeal Rights For Adverse Benefit Determinations**

After an adverse benefit determination, you may appeal the determination. Upon an appeal, the individual conducting the review will not be the individual who made the determination or the subordinate of that individual. The Plan provides for a process for expedited appeals of Certification Requests, which are urgent at the time of appeal, and a different process for standard appeals. All appeals must be submitted no later than 180 days after receipt of the notification of the initial adverse benefit determination. Any appeal submitted after 180 days will be invalid and denied.

1. **Making Expedited Appeals for Certification Requests which are Urgent at the Time of Appeal.** If an adverse benefit determination involves an Urgent or Standard Certification Request, which remains or becomes urgent at the time of the appeal, an expedited appeal may be initiated by a telephone call to the U.R. Administrator. "Urgent" means that the application of the usual time periods for determining appeals of Certification Request determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Certification Request. You or your authorized representative may appeal such a determination either orally or in writing. All necessary information, including the appeal determination, will be communicated by telephone, facsimile, or other similar method. You will be notified of the determination not later than 72 hours after the appeal is received. If a Member does not use this expedited appeal process for an Urgent or Standard Certification Request, which remains or becomes urgent at the time of appeal, the Member may appeal under the standard appeal process in Section 2 below.

2. **Making Standard Appeals.** To appeal an adverse benefit determination relating to a Certification, Post-Service Claim, or Emergency Services, you must file a written request for review of the determination. A request for review of a determination relating to Extensive Emergency Services, any Certification, or an ongoing course of treatment must be submitted to the U.R. Administrator. A request for review of a determination relating to a Post-Service Claim, including Standard Emergency Services, must be filed with the Plan Administrator. This standard appeal process does not apply to a determination on an Urgent or Standard Certification Request which remains or becomes urgent at the time of appeal and which is reviewed under the expedited appeal process described above in Section 1.
3. Review Process for All Appeals. An appeal reviewer will review the initial determination, and the Plan Administrator will make a determination on review.

The appeal reviewer will provide you reasonable access to review, or upon your request and free of charge, provide you with copies of, all documents, records and other information relevant to the Certification determination or claim for benefits, and the opportunity to submit written comments, documents and other information relating to the Certification determination or claim for benefits, which need not be limited to information submitted or considered in the initial determination. The appeal reviewer will also provide you an identification of medical or vocational experts, if any, whose advice was obtained on behalf of the Plan in connection with the initial determination, without regard to whether the advice was relied upon in making the determination. You will be entitled to have an authorized representative participate in all such review proceedings. The review will take into account all comments, documents, records and other information submitted by you relating to the Certification or claim and will not afford deference to the initial determination. If the initial determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appeal reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that health care professional will not be any individual who was consulted in connection with the initial determination or the subordinate of any such individual.

Within 72 hours (for Urgent or Standard Certification Requests which remain or become urgent at the time of appeal), 30 days (for Urgent or Standard Certification Requests which do not remain or become urgent at the time of appeal) or 60 days (for Post-Service Claims, including any Emergency Services) after the receipt of your request for review, the Plan Administrator will make, and give you written notice of, a final determination.

4. Manner and Content of Notification of Final Determinations. In the case of an adverse determination, the notice will include the following: 1) Specific reason(s) for the determination; and 2) Reference to the specific Plan provisions on which the determination was based; and 3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and 4) If an internal rule, guideline, protocol, or other similar criterion (a "criterion") was relied upon in making the determination, either the specific criterion, or a statement that such a criterion was relied upon and that a copy of it will be provided free of charge upon request; and 5) If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the judgment, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and 6) A statement of your right to bring an action under Section 502(a) of ERISA.

No lawsuit relating to a Certification Request, claim for benefits, or Certification or benefit determination may be filed in any state or Federal court by any claimant unless and until the claimant has duly filed the Certification Request or claim in accordance with the process described in the previous section, has also duly appealed the determination on the Certification Request, claim, or other matter in accordance with this section, and has received an adverse determination on review.
External Reviews

1. Overview. If your claim is denied, you may be eligible to have your claim reviewed by an Independent Review Organization (IRO) pursuant to a process called “External Review.” Generally, External Review is available only after your claim denial has been upheld after the final level of appeal under the Plan. You may, however, in limited circumstances have the right to have your claim reviewed by an IRO prior to exhausting the Plan’s appeal process. See Expedited External Review for further details.

External Review is Only Available for Medical Claims:

- Prior to January 1, 2012, External Review is available for medical claims except for denials of medical claims based on a determination that you were not covered under the Plan or that you were not eligible for coverage under the Plan at the time you incurred the medical claim. These denials are not subject to External Review.

- Beginning with requests for External Review initiated on or after January 1, 2012, External Review is available for medical claims that involve medical judgment (including, for example, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for Rescissions of Coverage.

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

2. The External Review Process. Your request for External Review must be filed in accordance with the instructions contained in your appeal denial notice and must be received not later than four months after the date you receive the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days after receiving your External Review request, the claims administrator will complete a preliminary review to determine whether your request is complete and eligible for External Review. That preliminary review will determine: whether you were covered under the Plan at the time the item or service was requested or provided; whether the final denial of your appeal related to your failure to meet the Plan’s eligibility requirements; whether you exhausted the Plan’s internal appeal process (or are not required to exhaust the process); and whether you have provided all the information and forms required to process an External Review. Within one business day after the claims administrator completes its preliminary review, it will issue you a written notification. If your request is complete, but not eligible for External Review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete,
the notification will describe the information or materials needed to make the request complete and you will be allowed to resubmit your request with the additional information for External Review within the 48-hour period which follows your receipt of the notification or within the original four month filing period, if later.

If your request for External Review is complete and eligible, the claims administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the claims administrator considered in making its final appeal denial.

You will be given up to 10 days to submit additional information to the IRO. If you submit additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan does not reverse its determination, the IRO will review all of the information and documents received and will not be bound by any decisions or conclusions reached by the claims administrator during the Plan’s internal claim and appeal process. The IRO may also consider the following in reaching its decision: your medical records; the attending health care professional’s recommendation; reports from the appropriate health care professionals and other documents submitted by the claims administrator, you or your treating provider; the terms of the Plan, to ensure that the IRO’s decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO’s clinical reviewer(s).

The IRO will provide written notice to you and the claims administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. The IRO’s notice will contain, to the extent required by law: a general description of the reason for the request for External Review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial; the date the IRO received the assignment and the date of the IRO’s decision; references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards; a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you; a statement that judicial review may be available to you; and, if applicable, current contact information for any applicable office of health insurance consumer assistance or ombudsman. If the IRO reverses the Plan’s determination, the Plan must immediately provide coverage or payment for the claim.

3. Expedited External Review. Under the following circumstances, you may be eligible to file for an expedited External Review:

- If you receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the claims administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
If you receive a final appeal denial from the claims administrator and:

- appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or

- if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the claims administrator will complete a preliminary review of your request in order to determine your eligibility for External Review. Immediately after completion of the preliminary review, the claims administrator will issue you a written notification of your eligibility for External Review. If your request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the claims administrator will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to you and the claims administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

CLAIMS PROCEDURES – SHORT TERM DISABILITY BENEFITS

How To File A Claim

The Plan Administrator, Smithfield, processes short-term disability benefit claims under the Plan and has full discretion to review and resolve all claims.

You must submit a claim for payment on such form as the Plan Administrator directs within 90 days after a disability occurs. Late filed claims will be invalid and denied. You may file claims for disability benefits either yourself or through an authorized representative. An "authorized representative" generally means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

If the Plan Administrator requests additional information regarding your claim, that additional information must be supplied within 90 days of the Plan Administrator’s first written request for the additional information or your claims will be denied.
To receive disability benefits, you must provide the Plan Administrator with a statement signed by your physician (other than a chiropractor) setting forth the nature of the disability, its cause and expected duration, your symptoms, the date the injury or illness triggering the disability occurred, the physician's diagnosis, the dates and nature of treatments rendered, the progress you have made towards recovery, the prognosis, and the physician's taxpayer identification number. This statement must be received by the Plan Administrator within ninety (90) days after the date your disability began or your claim will be invalid and denied.

The physician's statement must also include information regarding your suitability for rehabilitation. The Plan Administrator may also require you to submit to one or more examinations by a second physician appointed by the Plan Administrator. Failure to submit to such examination(s) will result in denial or termination of benefits.

**Initial Benefit Determinations**

1. **Decision by Claim Reviewer.** Following receipt of your claim by the Plan Administrator, a claim reviewer designated by the Plan Administrator will review your claim and make a determination. The claims reviewer must make this decision and notify you within 45 days after the initial claim for benefits is received, except that if matters beyond the control of the Plan require one or two extensions of time for processing the claim, the time for the initial determination may be extended by the claim reviewer up to an additional 30 days per extension. Written notice of any extension will be furnished to you before commencement of any extension, indicating the special circumstances requiring the extension and the date by which the claims reviewer expects to render the decision. Any notice of extension will specifically explain the standards on which your entitlement to a Plan benefit is based, the unresolved issues that prevent a determination on your claim, and any additional information needed to resolve those issues. If additional information is needed, you will have at least 45 days within which to provide the information, and the extension will not begin until the claims reviewer receives your response. If the claims reviewer does not receive any such additional information within 45 days of your receipt of a request for information, the claims reviewer will deny the claim.

2. **Manner and Content of Notification.** The Plan will provide you with written notification of its determination as to your short-term disability claim. If the Plan denies a benefit, or reduces, terminates, or fails to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in the Plan, the Plan's decision will be an "adverse benefit determination." In the case of an adverse benefit determination, the notification to you will include the following: 1) The specific reason(s) for the determination; and 2) Reference to specific Plan provisions on which the determination is based; and 3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why the material or information is necessary; and 4) Information as to the steps to be taken if you wish to submit the claim for review, including the time limits; and 5) A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), following an adverse benefit determination on review; and 6) If an internal rule, guideline, protocol, or other similar criterion (a "criterion") was relied upon in making the determination, either the specific criterion or a statement that such a criterion was relied upon in making the determination and that a copy of it...
will be provided free of charge to you upon request; and 7) If the determination is based on a scientific or clinical judgment, either an explanation of the scientific or clinical judgment on which the determination is based, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon your request.

No lawsuit relating to a claim for benefits may be filed in any state or Federal court by any claimant unless and until the claimant has duly filed the claim in accordance with the process described in this section, has also duly filed a request for review of the determination of the claim in accordance with the following section describing Appeal Rights for Adverse Benefit Determinations and has also received an adverse determination on review.

**Appeal Rights for Adverse Benefit Determinations**

After an adverse benefit determination of your short-term disability benefits claim, you will have 180 days in which to file a written request with the Plan Administrator for review of the decision by an appeal reviewer who is not the individual who determined your claim or the subordinate of the individual. The appeal reviewer will provide you reasonable access to review, or upon your request and free of charge, provide you with copies of, all documents, records and other information relating to the claim for benefits, which need not be limited to information submitted or considered in the initial determination. The appeal reviewer will also provide you an identification of medical or vocational experts, if any, whose advice was obtained on behalf of the Plan in connection with the initial determination, without regard to whether the advice was relied upon in making the determination. You will be entitled to have an authorized representative participate in all such review proceedings. The review will take into account all comments, documents, records and other information submitted by you relating to the claim and will not afford deference to the initial determination. If the initial determination was based in whole or in part on a medical judgment, the appeal reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that health care professional will not be any individual who was consulted in connection with the initial determination or the subordinate of any such individual.

Normally, within 45 days after the Plan Administrator’s receipt of your request for review, the appeal reviewer will make, and give you written notice of, a final determination. In the case of an adverse benefit determination on review, the notice will include the following: 1) Specific reason(s) for the determination; and 2) Reference to the Plan provisions of the Plan on which the determination was based; and 3) A statement that you are entitled to information relevant to your claim for benefits; and 4) If an internal rule, guideline, protocol, or other similar criterion (a “criterion”) was relied upon in making the determination, either the specific criterion, or a statement that such a criterion was relied upon and that a copy of it will be provided free of charge upon request; and 5) If the determination is based on a scientific or clinical judgment, either an explanation of the judgment, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and 6) A statement of your right to bring an action under Section 502(a) of ERISA. However, if special circumstances require an extension of time for processing a request for review, the appeal reviewer has the right to extend the time for processing the claim up to 45 days from the end of the initial 45-day period. In the event of an extension, the Plan will provide
to you written notice of the extension prior to termination of the initial 45-day period. Any such extension notice will indicate the special circumstances requiring an extension and the date by which the appeal reviewer expects to render the determination on review.

No lawsuit relating to a claim for benefits may be filed in any state or Federal court by any claimant unless and until the claimant has duly filed the claim in accordance with the process described in the previous section, has also duly filed a request for review of the claim determination in accordance with this section, and has also received an adverse determination on review.

**TIME LIMIT ON LEGAL ACTIONS**

No legal action may be brought against the Plan or the Plan Administrator more than twelve (12) months after the date on which the cause of action accrued with respect to any matter relating to the Plan.

| No lawsuit relating to a Certification Request, claim for benefits, Certification determination, or benefit determination may be filed in any court by any claimant more than twelve (12) months after the date on which the Plan Administrator has made a final adverse determination on review of an initial adverse benefit determination. |

**YOUR RIGHTS UNDER ERISA**

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:

**Receive Information about the Plan Documents**

Examine without charge the Plan documents, which are available for review at the Plan Administrator's office during regular working hours. You may obtain copies by submitting a written request to the Plan Administrator or your Human Resource department. A reasonable copying charge may be made.

This document is intended to provide you and your family with a clear description of the Plan. You should consult the Plan Administrator if you have any questions.

| The Plan document is the final authority and governs the benefits you receive. |

**Receive Other Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated plan document. The Administrator may make a reasonable charge for the copies.

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

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review the documents governing the Plan on the rules of your COBRA continuation coverage rights.

**Reduce or Eliminate Preexisting Conditions Exclusions**

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan (1) when you lose coverage under the Plan, (2) when you become entitled to elect COBRA continuation coverage, (3) when your COBRA continuation coverage ceases, (4) if you request a certificate before losing coverage, or (5) if you request a certificate up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan 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 pension benefit or exercising your rights under ERISA.

**Exercising and Enforcing Your Rights**

If your claim for a Plan 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, as described above in How to File a Claim, Initial Benefit Determinations, and Appeal Rights for Adverse Benefit Determinations.

Under ERISA, there are steps you can take to enforce the above 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 which is denied or ignored, in whole or in
part, and if you have completed the claims review process described above in the descriptions of How to File a Claim, Initial Benefit Determinations, and Appeal Rights for Adverse Benefit Determinations, 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.

**Assistance with Your Questions**

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 (formerly named the Pension and Welfare Benefits 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
**MORE INFORMATION ABOUT THE PLAN**

| Name of Plan                  | Smithfield Foods Health Care Program  
|                              | (Plan for Hourly Employees of Smithfield Packing Company – Smithfield South) |
| Type of Plan                 | Welfare – Medical |
| Plan Number                  | 501 |
| Plan Administrator and Sponsor | Smithfield Foods, Inc.  
|                              | P.O. Box 158  
|                              | Smithfield, Virginia 23431  
|                              | Attn: Health Care & Benefits Director  
|                              | Employer Identification No. 52-0845861  
|                              | (757) 365-1754 or (800) 809-5916 |
| Agent for Service of Legal Process and Named Fiduciary | Health Care & Benefits Director  
|                              | Smithfield Foods, Inc.  
|                              | P.O. Box 158  
|                              | Smithfield, Virginia 23431 |
| Insurance Contract/Funding   | Self-insured and unfunded (No trust) |
| Claims Administrator         | Smithfield Foods, Inc.  
|                              | P.O. Box 158  
|                              | Smithfield, VA 23431  
|                              | (757) 365-1754 or (800) 809-5916 |
| Plan Records                 | Plan records are kept on a Plan Year basis |
| Plan Year                    | January 1 – December 31 |
| Participating Employers:     | Smithfield Foods, Inc.  
|                              | Smithfield Packing Company, Inc. |
SMITHFIELD FOODS HEALTH CARE PROGRAM
NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Smithfield Foods Health Care Program (the "Plan"), sponsored by Smithfield Foods, Inc. (the "Company") respects the privacy of your protected health information. "Protected health information", or "PHI", includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

This Notice applies to all PHI we receive or create, and informs you about how we may use or disclose your PHI. It also describes your rights and our obligations regarding your PHI. This Notice applies to all of the Company's current and future benefit plans that provide, or pay the cost of, medical care.

We reserve the right to change the terms of this Notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a copy of our most current Notice at the address listed in Section VIII.

I. PERMITTED USES AND DISCLOSURES

Your PHI may be used or disclosed for purposes of treatment, payment and health care operations, and under limited circumstances, to the Company.

A. Treatment means the provision, coordination or management of your health care. We may disclose your PHI to health care providers involved in your care. For example, if you are unable to provide your medical history to an emergency room physician assisting you, we may provide it for you.

B. Payment means activities we undertake to obtain or provide reimbursement for the health care services you receive, including determinations of coverage and other utilization review activities. For example, we may use information received from your doctor to process claims for treatment you received at the doctor's office.

C. Health Care Operations means the management and administrative activities we undertake to operate the Plan, such as quality assurance activities, case management, and responding to inquiries from plan participants. For example, we may use PHI to determine what coverages we should provide in the future.

D. The Company. We may disclose your PHI to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to Company employees assigned to the Smithfield Foods, Inc. Corporate Health Care & Benefits department, which administers the health plans. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by us to any other Company employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection
with any other employee benefit plan sponsored by the Company.

II. USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

A. Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose your PHI to a family member or close friend who is involved in your care. The information shared will be limited to information directly relevant to that person's involvement in your care. You may object to such disclosures at the time the disclosure is to be made. If you are not available to object, we will determine whether such disclosure is in your best interest.

B. Disaster Relief. We may disclose your PHI to an organization assisting in a disaster relief effort. You may object to such disclosure at the time the disclosure is to be made. If you are not available to object, we will determine whether such disclosure is in your best interest.

III. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES

The following uses and disclosures of PHI do not require your consent.

A. Treatment Alternatives; Health-Related Benefits and Services. We may use or disclose PHI to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

B. As Required by Law. We will disclose your PHI when required by law to do so.

C. Public Health Risks. We may disclose your PHI for public health activities. These activities may include, for example, disclosure to:

- prevent or control disease, injury or disability;
- report births and deaths;
- report child abuse or neglect;
- report reactions to medications or problems with products;
- notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

D. Reporting Abuse or Neglect. We may use your PHI to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

E. Health Oversight Activities. We may disclose your PHI to federal or state agencies that oversee our activities. For example, we may disclose PHI for audits or other investigations as necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

F. Lawsuits and Disputes. We may disclose your PHI in response to a court or administrative order, a subpoena, a discovery request, or other lawful process. In some cases, law will require that efforts be made to tell you about the request or to obtain an order protecting the information requested.

G. Law Enforcement. We may release your PHI for certain law enforcement purposes, including:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- When information is requested about the victim of a crime if, under limited circumstances, we are unable to obtain the person's agreement;
To report information about a suspicious death;
- To report a crime; and
- Where necessary to identify or apprehend a person in relation to a violent crime or an escape from lawful custody.

H. Coroners and Funeral Directors. We may release your PHI to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death. We may also release your PHI to funeral directors as necessary to carry out their duties.

I. Organ and Tissue Donation. If you are a donor, we may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

J. Research. Under certain circumstances, we may use or disclose PHI for research purposes. For example, a research project may involve comparing the health and recovery of plan participants who received different treatments for the same condition. PHI may be used for research purposes only if the privacy aspects of the research have been reviewed and approved by a special review board, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

K. Serious Threats. As permitted by law and standards of ethical conduct, we may use and disclose your PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

L. Military and Veterans. If you are a member of the armed forces, we may release your PHI as required by military authorities.

M. National Security and Intelligence Activities; Protective Services. We may release your PHI to authorized federal officials for intelligence or other national security activities authorized by law, or as needed to provide protection to the President or other authorized persons or to conduct special investigations.

N. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

O. Worker’s Compensation. We may release your PHI for programs that provide benefits for work-related injuries or illness.

IV. AUTHORIZATION REQUIRED FOR OTHER USES

We will not use or disclose your PHI for purposes other than as permitted in Sections I, II and III above without your prior written authorization.

If you provide a written authorization for an otherwise impermissible use or disclosure, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for purposes covered by the authorization, except to the extent in which we have already relied on the authorization.

V. YOUR RIGHTS REGARDING YOUR PHI

The law provides you certain rights regarding your PHI maintained by the Plan.
To exercise any of the following rights, please contact the person listed in Section VIII.

A. Right to Access. You have the right to inspect and copy your PHI, with limited exceptions. If you are denied access, you may request the denial be reviewed. The person who conducts the review will not be the person who denied your request.

We may charge a reasonable fee for the cost of copying and delivering the requested information.

B. Right to Request Restrictions. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request, unless it is a request to restrict disclosure of information pertaining solely to an item you have paid for in full out-of-pocket.

C. Right to Request Confidential Communications. You have the right to reasonably request to receive communications of PHI by alternative means or at alternative locations. For example, you can request that we contact you only at a certain phone number. We will attempt to accommodate your reasonable requests.

D. Right to Request Amendment. You have the right to request a correction to your PHI, however, we may deny this request if we determine that the PHI or record that is the subject of the request:

1. was not created by us, unless the originator of PHI is no longer available to act on the requested amendment;
2. is not part of your medical or billing records;
3. is restricted by law; or
4. is accurate and complete, as determined by the Plan.

If we deny your request for amendment, we will give you a written reason for the denial and the right to submit a written statement disagreeing with the denial.

E. Right to an Accounting of Disclosures. You have the right to request a listing of certain disclosures of your PHI made by us or by others on our behalf. This listing does not include disclosures for treatment, payment and health care operations or certain other exceptions as required or permitted by law.

To request an accounting of disclosures, you must submit a request in writing, stating a time period beginning after January 1, 2004. An accounting will include, if requested: the disclosure date; the name and address, if known, of the recipient of the PHI; a brief description of the PHI disclosed; a brief statement of the purpose of the disclosure or a copy of the authorization or request; or certain summary information concerning multiple similar disclosures. The first accounting provided within a twelve (12) month period will be free; for additional requests, we may charge you our costs.

Right to a Paper Copy of this Notice. You have the right to request and receive a paper copy of this Notice from us.

VI. BREACH NOTIFICATION

If we discover a breach of your unsecured PHI which compromises its security or privacy, we will notify you within sixty (60) days. In some circumstances, we are required to also notify the Secretary of Health and Human Services and the media; however, such notification will not identify you personally.
VII. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with the Plan or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the person listed in Section VIII.

We will not retaliate against you if you file a complaint.

VIII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised Notice provisions effective for all PHI already received and maintained by us as well as for all PHI we receive in the future. Within sixty (60) days of a material change to this Notice, we will provide a copy of the revised Notice to the Company employees and individuals electing COBRA continuation coverage who are participating in the Plan at that time.

IX. FOR FURTHER INFORMATION

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Manager, Smithfield Foods, Inc. Corporate Health Care & Benefits, Smithfield Foods, Inc., P.O. Box 158, Smithfield, VA 23431; (757) 365-1754 or (800) 809-5916.

This Notice is effective as of January 1, 2013.
SCHEDULE A
SMITHFIELD FOODS HEALTH CARE PROGRAM

EXCLUSIONS

1. **General Exclusions.** In addition to the Plan's other restrictions, no Plan benefit is payable for any of the following excluded items:

   a) Care, treatment or supplies for which the charge was incurred before or after the patient was covered under the Plan.

   b) Services, treatments and supplies which are not specified as Covered Services under the Plan.

   c) Charges incurred for which the Member has no legal obligation to pay.

   d) Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment – if in the case of a Member whose Injury or Illness arises from work as an Employee, the Member is compensated for the care and treatment under the Employer's workers compensation coverage (including any expenses for care and treatment that are applied towards satisfaction of any deductible under the Employer's workers compensation coverage), or the care and treatment could have been compensated under the Employer's workers compensation coverage if the Member had complied with applicable requirements to be compensated, such as notice of injury, timely filing of claims and medical treatment authorizations.

   e) Care, treatment, services or supplies not recommended and approved by a physician or chiropractor; or treatment, services or supplies when the Member is not under the regular care of a physician or chiropractor. Regular care means ongoing medical supervision with plan of treatment and follow-up care appropriate for the injury or illness.

   f) Care and treatment for which there would not have been a charge if no coverage had been in force.

   g) Care, treatment or supplies furnished by a program or agency funded by any government agency. This exclusion does not apply to Medicaid or when otherwise prohibited by law.

   h) Care and treatment that is either experimental/investigational or not medically necessary.

   i) Care, treatment, supplies or related services that would be otherwise considered Covered Services under the Plan, to the extent that the charges for such services are in excess of limits established under the Plan.

   j) The part of an expense for care and treatment of an injury or illness that is in excess of the usual and reasonable charge.
k) Charges for services received as a result of injury or illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

l) Any loss that is due to a declared or undeclared act of war, if payment is available through Workers Compensation or a Government program or service.

m) All diagnostic and treatment services related to the treatment of Temporomandibular Joint (TMJ) syndrome.

n) Professional services performed by a person who ordinarily resides in the Member's home or is related to the Member as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

o) Care and treatment provided for cosmetic reasons or palliative foot care, including cosmetic surgery. This exclusion will not apply if the care and treatment is for repair of damage from an injury that occurred while the Member was covered under the Plan; or is for correction of an abnormal congenital condition in a Child, continuously covered since birth. Reconstructive mammoplasty will be covered after medically necessary surgery, provided the reconstruction is performed within five years of the mastectomy and providing the Member was covered under the Plan at the time of the mastectomy.

p) Radial keratotomy or other eye surgery to correct near-sightedness or far-sightedness. Also, excluded are eye examinations, including refractions, lenses for the eyes and exams for their fitting.

q) Except for Well Baby Care Services through age six (6) and the Annual Physicals for covered adult members (employees and their spouses), charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, illness or pregnancy-related condition which is known or reasonably suspected. For example, sports, school and camp physicals are not covered.

r) Services or supplies provided mainly as a rest cure, maintenance or custodial care.

s) Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless medically necessary due to sufficient change in the Member's physical condition to making the original device no longer functional. Charges for services or supplies related to replacement of braces damaged or no longer functional due to willful destruction are not covered.

t) Services or supplies for special, remedial, health or any other education or for educational or vocational testing or training, whether or not given in a facility that also provides health care and whether or not related to an illness or injury.

u) Professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility and paid by the hospital or facility for the service.
v) Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

w) Care, services and treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

x) Charges for care and services related to reversal of sterilizations are not covered.

y) Care and treatment for infertility, artificial insemination or in vitro fertilization.

z) Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician.

aa) Care and treatment for nicotine dependence programs and hypnotherapy.

bb) Care and treatment for sleep disorders unless deemed medically necessary approved by prior authorization.

c) Exercise programs for treatment of any condition, except for physician-supervised occupational or physical therapy covered by the Plan.

dd) Loss due to failure to wear a seat belt when a Member is operating, or riding in, a vehicle equipped with seatbelts, or loss due to failure to wear a motorcycle helmet while operating, or riding on, a motorcycle or all-terrain vehicle where legally required to wear such equipment and when the Member has reached their twenty-first (21st) birthday.

e) Services, supplies, care or treatment in connection with an abortion unless medically necessary.

ff) Care and treatment related to Impulse Control Disorder.

gg) Care and treatment billed by a hospital for non-medical emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

hh) Care, services or treatment required as a result of complications from a treatment or condition not covered under the Plan.

ii) Charges for travel or accommodations, whether or not recommended by a Physician, except for covered ambulance charges or for approved organ transplant services through a Center of Excellence provider.

jj) Services, supplies, care or treatment to a Member for injury or illness resulting from that Member's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician, when the Member has reached their twenty-first (21st) birthday.
kk) Services, supplies, care or treatment to a Member for an injury or illness which occurred as a result of that Member's illegal use of alcohol or operation of a motor vehicle under the influence of alcohol, when the Member has reached their twenty-first (21st) birthday.

ll) Pregnancy or family planning benefits or abortion services for Children when the Child Relative Member has reached their twenty-first (21st) birthday.

mm) Hospital emergency room facility fees for services and visits unless such services are rendered in connection with a true "Emergency" which is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in – (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part and requires the Member to seek immediate medical attention.

nn) Care or treatment of any injury or illness caused, exacerbated or worsened by the Member's (or in the case of a minor Child, their parent's) intentional or negligent disregard of, or failure to follow, the medical advice, recommendations or directions of the Member's attending Physician, Hospital or other Health Care professional (including, by way of example, use of un-prescribed "alternative" treatments and "home remedies" in lieu of procedures and/or medicines recommended or prescribed by the Member's attending Physician or leaving a Hospital against Physician or Hospital advice).

oo) Charges for administrative physician telephone consultations, missed appointments and filling out forms.

pp) Physician service charges incurred by a Member in a single visit to a physician's office that are billed by the provider as more than one (1) office visit, except in cases where a routine preventative wellness visit and an office visit or other outpatient services are billed.

qq) Professional pathology or radiology charges, including but not limited to, blood counts, multichannel testing, and other clinical chemistry tests, when:

(1) The services do not require a professional interpretation; or
(2) The qualified practitioner did not provide a specific professional interpretation of the test results of the covered person.

rr) Any drug or medicine (including injectables and excluding drugs and medicines for covered chemotherapy or dialysis treatment), which is included in physician, inpatient hospital, outpatient or other services that would otherwise be considered Covered Services, unless the drug's or medicine's consumption by or administration to a Member has been submitted for advance review and has been approved pursuant to the Plan's U.R. Program.

ss) Injections of prescription drugs by a health care professional, which can be self-administered, unless medical supervision is required.

tt) Costs in excess of the allowed amount for services and supplies usually provided
by one medical provider, when those services are provided by multiple providers or medical care and supplies provided by more than one provider for treatment of the same condition.

uu) Court ordered services unless documented to be medically necessary.

vv) Charges for services related to DNA testing.

ww) Charges for care and services related to genetic testing and counseling.

xx) Inpatient admission for therapy services except continuation of approved inpatient stays.

yy) Dental hospital admissions, inpatient or outpatient. except when medically necessary.

zz) Care, treatment or services from in-training providers.

aaa) Care, treatment or services for Bereavement Counseling.

bbb) Marital or Premarital Counseling services.

ccc) Charges for services related to Magnetic Resonance Imaging Virtual Colonoscopy or Magnetic Resonance Imaging Colonography.

ddd) Charges related to Lactation Consultant services or supplies, except during mother’s inpatient stay.

eee) Care, treatment or services for sexual dysfunction unrelated to organic disease.

fff) Charges for food supplement or augmentation, except to sustain life when medically necessary or for specific inborn errors of metabolism.

ggg) Charges related to motorized transportation equipment and alterations to vehicle or home.

hhh) Charges for services, supplies, care and treatment received as a result of injury or illness caused by or contributed to by engaging in High Risk Activities unless the proper safety equipment is worn.

2. Prescription Drug Benefits Exclusions. The Plan does not cover a charge for Prescription Drugs related to or arising out of or with respect to medical services supplies, care and treatment and drugs and medicines excluded under Section 1 above or any of the following:

a) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or other over-the-counter drugs covered on the formulary;

b) Vitamins and supplements, nutrition or dietary; except for prenatal vitamins as medically appropriate;
c) Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, contraceptive devices, artificial appliances, braces, support garments, or any similar device;

d) Charges for growth hormone drugs or stimulants;

e) A drug or medicine labeled: "Caution - limited by federal law to investigational use";

f) Experimental drugs and medicines, even though a charge is made to the Member;

g) Any charge for the administration of a covered prescription drug;

h) Any drug or medicine (including injectables and excluding drugs and medicines for covered chemotherapy or dialysis treatment) that is to be consumed by or administered to a Member in whole or in part at the place where it is dispensed (including any outpatient facility);

i) Any drug or medicine (including injectables) that is to be consumed by or administered to a Member in whole or in part while confined in a hospital or other medical facility, including confinement in any institution that has a facility for the dispensing of drugs and medicines on its premises;

j) A charge for prescription drugs which may be properly received without charge under local, state or federal programs;

k) A charge for hypodermic syringes and/or needles;

l) A charge for nicotine dependence drugs; except for course of treatment a year; and

m) A charge for infertility medication.
SCHEDULE B
SMITHFIELD FOODS HEALTH CARE PROGRAM
NETWORK PROVIDERS

(As of January 1, 2013)

Anthem Blue Cross & Blue Shield (BCBS) PPO Network

A comprehensive directory of all Network Providers is available on the Anthem BCBS website at www.anthem.com or you may contact the Plan Administrator, Smithfield Foods Health Care Program, for assistance.
SCHEDULE C
SMITHFIELD FOODS HEALTH CARE PROGRAM

NETWORK SERVICE AREA

(As of January 1, 2013)

The United States of America and International Travel
SCHEDULE D
SMITHFIELD FOODS HEALTH CARE PROGRAM

COPAYMENTS

(As of January 1, 2013)

1. **Network Providers.**

   Except as provided below, for Covered Services provided by a Network Provider, the Member's Copayment is 25% (Plan pays 75%) (for example, Network Inpatient Hospital Services, Network Outpatient Surgery and Services, or Physician Services rendered by a Network surgeon, pathologist, anesthesiologist, radiologist, emergency room physician, obstetrician/gynecologist, physical therapist or other Network primary care physician or specialist).

2. **Services Not Provided by a Network Provider.**

   For Covered Services not provided by a Network Provider, except as provided below, the Member's Copayment is:

   a. 100% (Plan pays 0%) unless 2b applies; or

   b. 25% (Plan pays 75%) if the Plan Administrator determines that the Covered Services are not available from any appropriate Network Provider located within 50 miles of the Member's primary residence, or that the Covered Services are true Emergency Services provided by a Non-Network Provider that is nearer to the location of the Member than any appropriate Network Provider.

3. **Exceptions.** Notwithstanding Sections 1 and 2 above, the following special rules apply:

   a. **Routine Preventative Well Child Services.**

      In the case of Routine Preventative Services rendered by a Network Provider, the applicable Copayment is $0*. In the case of Routine Preventative Services not rendered by a Network Provider (2a.), the applicable Copayment percentages are 100% (Plan pays 0%).

   b. **Routine Preventative Services for Adults.**

      In the case of Routine Preventative Services rendered by a Network Provider, the applicable Copayment is $0*. In the case of Routine Services not rendered by a Network Provider (2a.), the applicable Copayment percentages are 100% (Plan pays 0%).

   c. **Routine Mammogram (Employee & Spouse).**

      In the case of Routine Annual Mammogram Cancer Screening Services rendered by a Network Provider, there is no Copayment requirement (Plan pays 100%)*. In the case of Routine Annual Mammogram Cancer Screening Services not rendered by a Network Provider (2a.), the applicable Copayment percentages are 100% (Plan pays 0%).
d. **Routine Colonoscopy (Employee & Spouse).**

In the case of Routine Annual Colonoscopy Cancer Screening Services rendered by a Network Provider, there is no Copayment requirement (Plan pays 100%)*. In the case of Routine Annual Colonoscopy Cancer Screening Services not rendered by a Network Provider (2a.), the applicable Copayment percentages are 100% (Plan pays 0%).

e. **Chiropractic Services.**

In the case of Covered Services which consist of Spinal Manipulation or Chiropractic Services, the applicable Copayment percentages are 50% (Plan pays 50%) for Spinal Manipulation/Chiropractic Care rendered by a Network Provider 18 visits per plan year and up to the $25 maximum per visit. Spinal Manipulation/Chiropractic Services rendered by Non-Network Providers are not covered.

f. **Emergency Services.**

In the case of Covered Services rendered by a Network Provider or by a Non-Network Provider, a $60 per visit Copayment applies. Thereafter the applicable Copayment percentages are 25% (Plan pays 75%). Services in the Emergency Room that are not a true emergency regardless of whether or not they are rendered by a Network Provider or by a Non-Network Provider are not covered.

g. **Psychiatric Care.**

(1) Outpatient Psychiatric Care Services - In the case of Covered Services which consist of Outpatient Mental Health Care Services or Outpatient Substance Abuse Care Services the applicable Copayment percentages are 25% (Plan pays 75%) for Outpatient Psychiatric Care rendered by a Network Provider. For Services Not Provided by a Network Provider, See #2 above.

(2) Inpatient Mental Health Care Services - In the case of Covered Services which consist of Inpatient Mental Health Care Services rendered by a Network Provider, the applicable copayment percentages are 25% (Plan pays 75%) for Inpatient Mental Health Care Services rendered by a Network Provider. For Services Not Provided by a Network Provider, See #2 above.

(3) Inpatient Substance Abuse Care Services - In the case of Covered Services which consist of Inpatient Substance Abuse Care Services rendered by a Network Provider, the applicable copayment percentages are 25% (Plan pays 75%) for Inpatient Mental Health Care Services rendered by a Network Provider. For Services Not Provided by a Network Provider, See #2 above.

4. **Deductibles.** All Copayments are computed after any applicable Deductibles and Non-Network Deductibles.

*As a Non-Grandfathered Plan, routine preventative services including colonoscopies and mammograms, as well as additional preventative care and screenings for woman are covered at
100% as long as they fall under the federal regulations. To obtain more information on eligible covered services, please visit www.healthcare.gov/prevention. Services not covered under these regulations are subject to the applicable cost share.