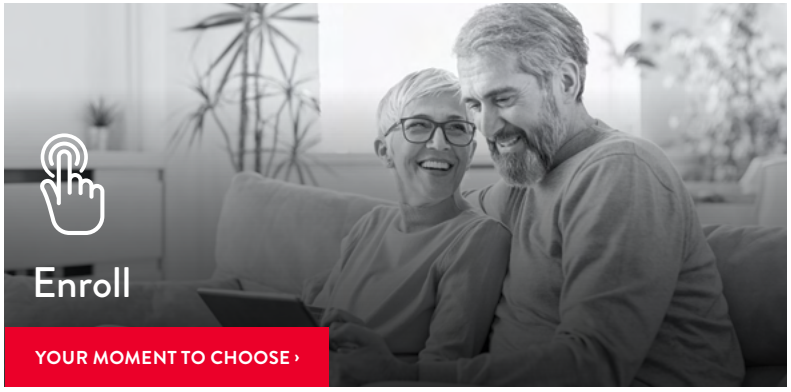
HERSHEY

START HERE | HEALTH | WEALTH | OTHER | RESOURCES | ENROLL

Health

YOUR WELLBEING MOMENTS ›



HOW TO NAVIGATE THIS GUIDE

NAVIGATE TO DIFFERENT SECTIONS OF THE GUIDE BY CLICKING ON THE MAIN SECTIONS AT THE TOP OF EACH PAGE

WHEN YOU REACH THE END OF A MAIN SECTION, CONTINUE TO THE NEXT ONE BY EITHER SCROLLING DOWN, CLICKING ON THE ARROWS NEXT TO THE PAGE NUMBER, OR CLICKING ON THE FOLLOWING MAIN SECTION

THE BOLD COLORED COPY INDICATES THE TOPIC YOU ARE CURRENTLY VIEWING

☆ NEW

This icon indicates highlights for 2021.

SEARCHING FOR A WORD?

Press Ctrl+F on a PC keyboard (or Command+F on a Mac keyboard). Then, type what you are looking for into the box that appears in the upper right corner of your screen.

LOOKING FOR SOMETHING?

- Use the navigation at the top to move from topic to topic but make sure to read each page within all sections, not just the first one.
- Use the links on each page to move between different sections by clicking on **underlined text** for links both within this guide and to our intranet and other websites.
- Be sure to click on the provider logos on each page — we linked them, so you will automatically be forwarded to the appropriate website.
- If you prefer to review this guide as a printed copy, simply go ahead and print this PDF by pressing Ctrl+P on a PC keyboard (or Command+P on a Mac keyboard).

HEALTH WEALTH

CHOOSE YOUR *moment*

Click below each section!

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2021 highlights

You have the opportunity to make benefit elections for you and your family after a qualifying life event (see page 10) or during Benefits Open Enrollment each year. Benefits Open Enrollment is a good time to take a fresh look at your (and your family's) health care costs from 2020, and think about your expected health care needs for 2021.

who

Benefit-eligible U.S. pre-65 retirees.

when

Benefits Open Enrollment begins Wednesday, October 28 and ends at 11:59 pm ET Wednesday, November 11. Your elections will go into effect January 1, 2021.

how

Review your Benefits Enrollment Statement, which is scheduled to mail on October 12, 2020, to see the cost of each medical plan option. Mark your selections on the Benefits Enrollment Statement and return it to the **HR Support Center** postmarked no later than November 11, 2020.

what else?

- Review and update your dependent information
- Review your election and be sure to make a copy of the Benefits Enrollment Statement for your records

need help?

Contact the **HR Support Center** at askHR@hersheys.com or call **1-800-878-0440** to ask questions and make informed health care decisions.

YOU MUST ENROLL IF...

...you want to make any changes to your health insurance options or add or remove any dependents.

You should always take a fresh look at the health care needs of you and your family during Benefits Open Enrollment, but if you decide you don't need to make any changes from 2020, you can rest easy knowing your elections will roll over to 2021 without needing to take action.

The elections you make or roll over during this year's Benefits Open Enrollment will be effective for the entire 2021 calendar year. You will not be able to change your elections until the next Benefits Open Enrollment period in 2021 unless you experience a qualifying life event (see page 10).

Please note: You will only receive new ID card(s) if you change plans or add or remove dependents.

BENEFITS-AT-A-GLANCE

HEALTH & WELFARE BENEFITS

Choice of Three Affordable Medical Plans:

HRA1 | HSA | HRA2

Prescription Drug Coverage

Voluntary Dental Plan

Voluntary Vision Plan

WELLBEING RESOURCES

Highmark Program:

- Member Advocacy
- Clinical Programs
- Health Management
- Blues on Call Health Coaching
- Sharecare

Preventive Exam

Sharecare Digital Health Companion

Tobacco Cessation Program

Healthcare Bluebook

ADDITIONAL BENEFITS

Best Doctors® (Free & Confidential)

Telemedicine including Mental Health visits and Dermatology ☆NEW

Highmark's Care Management

IMPORTANT NOTE:

As the U.S. benefits landscape evolves, we regularly evaluate Hershey's group insurance Medicare plans and how they compare to the many options available in the individual Medicare insurance market. We feel strongly that we want the best choice, coverage and options for our retirees. As we are evaluating our plans, Hershey recognizes that retirees who are eligible for Medicare, or may soon be eligible, may find greater choice and flexibility, with lower costs, in the individual Medicare market. Hershey wants to involve you in this conversation, and make you aware that we may have additional opportunities for this discussion in 2021.

Hershey values our retirees' dedicated service to Hershey. Look for more information and additional opportunities for education and dialogue throughout 2021.

ELIGIBILITY — WHO CAN I COVER?

As a U.S. pre-65 retiree, you are eligible to participate in the Hershey benefits program. You may choose to cover the following dependents:

- Your spouse
- Your domestic partner
- Children under the age of 26, regardless of status — student, married or tax-dependent
- Unmarried, disabled dependent children of any age who depend on you fully for support

Review and Verify Your Dependents

If you add a dependent to your coverage for 2021, you must contact the **HR Support Center** (see Contact Information for details) and submit the required documentation (e.g., social security number, date of birth, marriage certificate) before enrolling in benefits. Failure to provide documentation could result in a delay or loss of coverage for that dependent.

If you knowingly cover an ineligible dependent, you could be required to repay claims that are paid for that ineligible dependent.

DOMESTIC PARTNERS — HEALTH & WELFARE BENEFITS

If you cover a domestic partner, you must demonstrate your domestic partner meets Hershey's eligibility requirements. For more information about eligibility requirements, contact the **HR Support Center** as soon as possible.

BE AWARE OF WHEN YOUR CHILD WILL AGE OUT OF COVERAGE

You can cover eligible dependent children under the age of 26. This means that your eligible dependent children cannot remain on the plan after they turn 26.

Please note: when your dependent child becomes ineligible for coverage under your Hershey medical plan, they may be eligible to enroll in coverage through:

- his or her employer or spouse's employer
- COBRA (up to 36 months)
- the Health Insurance Marketplace

You can find more information on medical coverage options on HealthCare.gov, or by contacting the **HR Support Center** at 1-800-878-0440 or askHR@hersheys.com.

2021 BENEFITS OPEN ENROLLMENT

You Must Enroll if...

- You want to make any changes to your health insurance options
- You'd like to add or remove any dependents

It is wise to take a fresh look at the health care needs of you and your family during Benefits Open Enrollment, but if you decide you don't need to make any changes from 2020, you do not need to take action to receive the same comprehensive coverage.

Here's how it will work:

PLAN OPTIONS	If you take no action, you will remain in the same medical plan election you made for 2020, effective January 1, 2021
HRA1	at the same coverage level (e.g., individual, employee + 1, family) you elected for 2020
HSA	at the same coverage level you elected for 2020
HRA2	at the same coverage level you elected for 2020
Waive	No Hershey medical coverage

WHAT HAPPENS AFTER YOU ENROLL?

A Benefits Confirmation Statement will be mailed to you in late November, if you have made a change for 2021. Check your statement carefully to confirm that it reflects your correct medical plan election for 2021. **If you see an error, you must contact the HR Support Center at askHR@hersheys.com or 1-800-878-0440 immediately.**

If you make any medical plan changes during Benefits Open Enrollment or upon enrolling as a newly eligible retiree, Highmark will issue a new ID card for you and your dependents. Any questions, contact the **HR Support Center** at **1-800-878-0440** or at **askHR@hersheys.com**.

HEALTH CARE REFORM AND THE INDIVIDUAL MANDATE

Under the Patient Protection and Affordable Care Act (PPACA), most U.S. citizens must have medical coverage in 2021. It's important to know that Hershey's medical plans meet the minimum value requirements, are designed to satisfy the affordability requirements and meet the Individual Mandate requirement under the PPACA. Benefits Open Enrollment is your opportunity to enroll in a Hershey medical plan and ensure you and your family are covered in 2021.

BILLING FOR MEDICAL PLANS & COBRA

WageWorks is responsible for the billing administration for retiree medical and COBRA on behalf of The Hershey Company. On August 1, 2020 WageWorks moved to a new administrative platform; so, the invoicing procedures, phone number and website changed.

WageWorks customer service can be reached at the new telephone number **1-888-678-4881**, 7 a.m. to 7 p.m. CT, Monday through Friday (excluding company holidays). The new WageWorks website address is https://mybenefits.wageworks.com. All retirees are encouraged to go out to the new website and establish a username and password for their account.

Monthly invoices have replaced the coupon booklets. If you have your payments made via direct deposit you will not be mailed invoices.

Payment Methods

Submit premium payments three ways:

1. Your online account, which gives you the option to make one-time payments each month or set up recurring payments (automatic withdrawal of funds from your bank account each month). Note: If you previously set-up recurring payments, you will not need to re-enroll.

   The payment will be withdrawn between the 26th and 29th of the month prior to the due date.

2. Using the WageWorks interactive phone system at **1-888-678-4881**. Calls are toll-free and you can access the phone system 24 hours a day, seven days a week.

3. Mailing payments to this address:
   When sending a check or money order, please make it payable to WageWorks.

   Mail your payment to:
   WageWorks, Inc.
   P.O. Box 660212
   Dallas, TX 75266-0212

HOW TO REPORT A QUALIFYING LIFE EVENT

If you are making a change as a result of a life event, please call the **HR Support Center** at **1-800-878-0440** or email at **askHR@hersheys.com** and provide any required supporting documentation. **Remember, if you do not make changes within 31 days of the event, you must wait until the next Benefits Open Enrollment period to make changes.**

QUALIFYING LIFE EVENTS – CAN I MAKE CHANGES TO MY COVERAGE DURING THE YEAR?

Once you make your medical election for 2021, the elections will remain in effect for the full calendar year (January 1 through December 31). IRS regulations prohibit benefit changes during the year unless you experience a qualifying life event. If you experience a qualified life event you should notify Hershey as soon as possible, but you must make any changes within 31 days.

If you experience a qualifying life event, you must report the benefit change as soon as possible and provide supporting documentation to the **HR Support Center** within 31 days of the event. Any benefit change requested must be consistent with your qualified life event.

Benefit change requests reported more than 31 days after the life event date will not be granted. Absent a second qualifying life event during that year, the requested changes can only be processed during the next Benefits Open Enrollment period.

Eligible qualifying life events include:

- Marriage
- Divorce or legal separation
- Birth or adoption of a child
- Death of a spouse or dependent
- Start or termination of a spouse's employment
- Completion and approval of domestic partner application
- Change from part-time to full-time employment (or vice versa) for you or your spouse
- Unpaid leave of absence for you or your spouse
- Significant change in medical coverage because of spouse's employment
- Change in dependent status of your children

A BRIEF *moment* TO REVIEW THE 2021 MEDICAL PLAN OPTIONS

Offering a choice of medical plan options is important. Each of us has our own health care needs and preferences, and choosing a plan is a personal decision. For 2021, you will see the same comprehensive medical plan options as last year, with only a modest increase in contributions that is consistent with the expected cost increase for health care services in the U.S.

HRA1 **HSA** **HRA2**

All three plans are administered by Highmark, utilizing the same network of physicians, hospitals and other health care providers. They also cover the same benefits and services, including free preventive care if you visit an in-network provider and prescription drug coverage is automatically included. And don't forget, regardless of the plan you choose, Hershey makes contributions to your tax-advantaged account (either an HRA or HSA).

The plans differ by giving you a choice of the amount you pay per pay period for coverage and your cost when you receive care. All three options offer different contributions, deductibles and out-of-pocket maximums. Be sure to review the next page to determine which of these options best suit your health care budget and needs.

HEALTH

DID YOU KNOW?

Regardless of the medical plan option you select, preventive care is always 100% covered by your plan. You do not have to pay deductibles or coinsurance when you receive preventive care from a participating in-network provider.

Do something for your health today and schedule a preventive screening!

PROTECT *moments* THAT MATTER

MEDICAL PLAN BENEFITS-AT-A-GLANCE

	MEDICAL PLAN OPTIONS					
	HRA1		HSA		HRA2	
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,500 individual $3,000 family	$2,250 individual $4,500 family	$1,750 individual $3,500 family	$3,500 individual $7,000 family	$1,750 individual $3,500 family	$3,500 individual $5,850 family
Coinsurance	90% Company 10% Employee	70% Company 30% Employee	80% Company 20% Employee	60% Company 40% Employee	70% Company 30% Employee	50% Company 50% Employee
Annual OOPM	$2,200 individual $4,400 family	$4,400 individual $8,800 family	$2,500 individual $5,000 family	$5,000 individual $10,000 family	$3,000 individual $6,000 family	$6,000 individual $12,000 family
Deductible and OOPM Type	Embedded		Aggregate		Embedded	
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited	
Preventive Care (not subject to deductible)	100%	70% of MAC*	100%	60% of MAC*	100%	50% of MAC*
Office Visits	90%	70% of MAC*	80%	60% of MAC*	70%	50% of MAC*
Urgent Care	90%	90% of MAC*	80%	80% of MAC*	70%	70% of MAC*
Emergency Care	90%	90% of MAC*	80%	80% of MAC*	70%	70% of MAC*

Medical plan costs will vary by the coverage option you select. Your Benefits Statement shows the cost of each medical plan option which includes the monthly "overage" amount shown in the Health Care Cost Sharing section on ***page 14****, if applicable.*

** Maximum Allowable Charge*

Note: *Refer to* ***page 15*** *for definitions of aggregate versus embedded deductibles.*

HERSHEY'S TAX-ADVANTAGED SAVINGS ACCOUNTS

Each of our medical plans is paired with a savings account you can use to pay for eligible out-of-pocket health care costs. Regardless of which plan you select, Hershey will make a contribution to your account. Check out the table below for more details.

	MEDICAL PLAN OPTIONS		
	HRA1	HSA	HRA2
Type of account available	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	Health Reimbursement Account (HRA)
Hershey annual account funding	$500[1] individual only $1,000[1] individual + 1 $1,500[1] family	$750[2] individual only $1,500[2] individual + 1 $2,000[2] family	$300[1] individual only $600[1] individual + 1 $900[1] family
Retiree contributions	Retiree cannot make contributions to the HRA.	Your (post-tax) Maximum Contribution (per year)[3]: $2,850/yr individual only $5,700/yr individual + 1 $5,200/yr family	Retiree cannot make contributions to the HRA.

[1] *Hershey contributes to the HRA annually in January if you are enrolled in the plan as of the start of the year. If you enroll in the plan, during the year, Hershey will make a prorated contribution to your account following enrollment.*

[2] *Hershey contributes to the HSA on a quarterly basis (January, April, July, October) up to the annual contribution level. For example, if you select family coverage on January 1 under the HSA plan, you will receive four quarterly $500 contributions for a total Hershey annual contribution of $2,000.*

[3] *Because you are age 55 or older, you can contribute an additional $1,000 as a "catch-up" contribution to an HSA account.*

HEALTH CARE COST SHARING

If you are eligible for retiree medical coverage, you and Hershey share the cost of your coverage. Hershey's retiree health care cost-sharing arrangement is designed to protect medical benefits for retirees while sustaining the financial wellbeing of the company. This is how retiree medical cost sharing works:

- Cost-sharing percentages are determined by age and years of service at retirement.
- Hershey pays its cost share based on a "cap" amount.
- You pay your cost-sharing percentage plus any amount over the "cap" or the "overage".

The monthly costs for 2021 are set based on previous claims experience. The "overage" is $0 for 2021. Therefore, there is no additional monthly overage for pre-65 retirees in 2021. You will only pay your monthly amount as referenced on your Benefits Enrollment Statement.

Note: *If you are paying 100% of the retiree cost in the retiree medical program, the "overage" information does not apply to you. You are already paying the full cost.*

KEY TERMS

We have defined some key terms to help you understand how the medical plans work:

DEDUCTIBLE:

The amount you pay before the plan pays its portion of the costs for covered services subject to the deductible.

COINSURANCE:

A fixed percentage you pay for your share of the cost of a covered health care service, after you meet the deductible.

OUT-OF-POCKET MAXIMUM (OOPM):

The maximum amount you could pay — which includes your deductible and coinsurance — during a benefit period before your plan begins to pay 100% of the allowed amount for covered health care services.

"AGGREGATE" AND "EMBEDDED"

If you cover any family members, you need to understand how the deductible and out-of-pocket maximum are calculated. It's important because the approach the plan uses makes a difference as to when you pay the full costs out-of-pocket, when you and the plan share the cost (in the form of coinsurance) and when the plan starts paying the full expenses of covered health care services. .

- **Under an embedded approach (HRA plans)**, each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And once two or more family members meet the family limits, the plan begins paying its share for all covered family members.) This applies to our HRA plans.
- **Under an aggregate approach (HSA plan)**, there is one family limit that applies to the whole family. When one, or a combination of family members, has expenses that meet the family deductible or out-of-pocket maximum, it is considered to be met for all of you. Then, the plan will begin paying its share of eligible expenses for the whole family for the rest of the year. The HSA plan is an aggregate approach if you have EE + 1 or family coverage.

HOW THE MEDICAL PLANS WORK

While it's important to choose benefits that best meet your needs, it's equally important to understand how they work and use them wisely throughout the year. Regardless of which plan you choose, they generally work the same way.

YOU PAY › WHEN YOU RECEIVE CARE › YOU PAY

COST-SHARING % + "OVERAGE"

You and Hershey share the cost of your retiree medical coverage. You pay your cost-sharing percentage each month plus the "overage", if applicable.

BEFORE YOU SATISFY YOUR DEDUCTIBLE

You pay the full costs (including prescription drug costs for the HSA).

YOU PAY › PLAN PAYS

ONCE YOU SATISFY YOUR ANNUAL DEDUCTIBLE

You pay a coinsurance percentage for each covered service and the plan pays the remaining balance.

PLAN PAYS 100%

IF YOU REACH YOUR ANNUAL OUT-OF-POCKET MAXIMUM

The plan pays 100% of the cost for covered services for the rest of the year.

Hershey understands that it can be challenging to pick the right medical coverage. While our three medical plans generally work the same, there are some important differences to note in how the annual deductible and out-of-pocket maximum are calculated if you cover any family members under the HSA and the HRA plans.

HOW CAN I SAVE MORE?

- When you use in-network providers, you benefit from a negotiated discount.
- In-network preventive care is always 100% covered.
- Use the available funds in your HRA or HSA to pay for eligible health care expenses throughout the year.

Note: *Highmark Blue Shield will automatically use available funds from your HRA first to pay your claims until your balance is exhausted.*

PRESCRIPTION DRUG COVERAGE

When you enroll in a Hershey medical plan option, you are automatically enrolled in prescription drug coverage. The Hershey Company partners with Express Scripts as the prescription drug administrator. You will receive a separate prescription drug ID card that you must present at the pharmacy.

	PRESCRIPTION DRUGS		
IN-NETWORK	HRA1	HSA	HRA2
Annual Deductible	No deductible	Deductible is made up of a combination of medical and prescription costs	No deductible
Prescription Drug Coinsurance (retail and mail order)	80% generic, 60% brand	Pharmacy expenses count toward medical deductible; once the total deductible has been met, prescription benefits are covered at 80% generic, 60% brand	80% generic, 60% brand
Out-of-Pocket Maximums	$1,500 individual, $3,000 family *(Separate from medical plan)*	Included under medical plan out-of-pocket maximum	$1,500 individual, $3,000 family *(Separate from medical plan)*
No Cost Share — services covered 100% by the plan	Women's Health, Preventive Medications, Certain Generic and OTC Products, Smoking Cessation		

Note: *If you purchase a brand-name drug that is not specified by your doctor or when a generic is available, you must pay the difference between the brand name and the available generic drug in addition to your coinsurance.*

- Out-of-network pharmacies and prescription services are not covered.

- Drugs are paid at 100% after out-of-pocket maximum is met.

Note: *Please check the Express Scripts website for the latest formulary changes.*

It is important to note, in the HSA plan, the deductible is made up of a combination of medical and prescription costs. For prescriptions, participants pay 100% of the discounted drug price until the medical deductible is met, then you pay 20% of the cost of a generic and 40% of the cost of a brand name drug until the out-of-pocket maximum is met.

PRESCRIPTION HOME DELIVERY...

EXPRESS SCRIPTS SELECT HOME DELIVERY-ACTIVE CHOICE

Ordering or refilling your medicine from home or on the go has never been easier. There's no extra cost... and you'll often pay less for a 90-day supply of your medication than you'd pay at a retail pharmacy.

After your first two retail fills of a new maintenance drug prescription, you will be contacted by Express Scripts and provided with simple instructions for communicating whether you would like to stay at retail or move to home delivery. There's no penalty regardless of your choice. However, if you do not contact Express Scripts and indicate a choice, you will pay 100% of cost on your third and subsequent retail prescription fill until a decision is communicated to Express Scripts. You can change your decision at any time with no penalty by simply notifying Express Scripts.

SPECIALTY PHARMACY COPAY ASSISTANCE PROGRAM

Hershey has a specialty pharmacy copay assistance program*, to help offset the cost of **select specialty pharmacy medications**. **If you enroll in the specialty pharmacy copay assistance program** the **cost of the medication** will be covered by the manufacturer at no cost to you.

If you enroll in the HSA plan, you may not enroll in the specialty pharmacy copay assistance program until you have satisfied your annual deductible. Enrollment in the specialty pharmacy copay assistance program prior to satisfying your plan deductible will make you ineligible to participate in the HSA. This restriction does not apply to the HRA 1 or HRA 2 medical plans.

Also, manufacturer-funded copay assistance for widely distributed specialty drugs will not be considered an out-of-pocket cost for participants and will not count toward the annual deductible or out-of-pocket maximum. Only the amount you pay will be applied to your deductible and/or out-of-pocket maximum.

For a full list of specialty medications eligible for this program and information on how to enroll, visit the Express Scripts website and search specialty drug or copay assistance.

* *"Copay assistance" may also be referred to as financial assistance, manufacturer coupons, discount programs and/or coupon programs.*

EXPRESS SCRIPTS SELECT HOME SERVICE

convenience. No need for monthly trips to the pharmacy; medications are delivered right to your door... and you can order refills by mail, phone or online using the Express Scripts member website or mobile application.

service. Your prescriptions are checked for accuracy and potential drug interactions by registered pharmacists who are available to answer questions 24 hours a day, every day.

it's easy. Simply register or log in from the convenience of your computer or mobile device:

1. Go to Express-Scripts.com
2. Click on "Register Now"
3. Enter your information — be sure to have your member ID number, which is on the front of your ID card, or Social Security number ready — and create a log in

SAFELY ACCESS MEDICAL SERVICES AND SAVE TIME AND MONEY WITH TELADOC!

If you enroll in a Hershey medical plan, you have access to Teladoc, a service that provides you with access anytime to U.S. board-certified physicians. Teladoc makes it possible to talk with a physician without having to make an appointment, take time off from work or wait for hours in a crowded doctor's office full of sick people.

Virtual doctor visits replace the need to visit a doctor's office for non-emergency health conditions, provide around-the-clock, immediate care, advice and prescription medications when appropriate.

☆ NEW In addition to general medicine, you now have **Teledermatology** services available to treat non-emergency dermatology conditions like acne, rash, shingles and more.

☆ NEW And more than that, **Virtual Behavioral Health** (VBH) is available. Talk to a psychiatrist, psychologist, or a counselor for anything from depression and anxiety to family difficulties. Get the mental and emotional support you need, from the comfort of your own couch.

Teladoc is an easy, convenient way to get medical care for non-emergency issues, such as:

- Sore throats
- Allergies
- Cold / Flu
- Ear infections
- Respiratory problems
- Prescriptions (if needed)
- And more

Eligibility & Costs

You must be a participant in one of Hershey's medical plans in order to receive services through Teladoc.

Teladoc consultations vary based on level of service, but most general medicine consultations are $40 or less for all members. Teledermatology consultations are $75, and Mental Health consultations range from $80 to $160. You will be required to pay the applicable cost for any prescriptions you receive through Express Scripts for this service.

Note that before you can use services through Teladoc, you need to register on their website. Visit **www.teladoc.com/enter** or call **1-800-835-2362**.

TELADOC

PREVENTIVE CARE... AT NO COST TO YOU!

Preventive screenings are key to avoiding potential serious health conditions. When you and your doctor work as a team, you can receive early diagnosis and treatment of health issues that, if left untreated, could develop into more serious, costly, long-term conditions.

Regardless of the medical plan option you select, preventive care is always 100% covered by your plan. You do not have to pay deductibles or coinsurance when you receive preventive care from a participating in-network provider.

Preventive care includes services such as annual physicals, gynecological annual exams, mammograms, colonoscopies, age/gender appropriate screenings, well child visits and immunizations. For the most up to date list of covered preventive care services, contact Highmark at **1-866-763-9474** or visit **www.highmarkblueshield.com**.

GET THE RIGHT CARE — THE *moment* YOU NEED IT

Hershey medical plans cover eligible services from a variety of providers and facilities. In addition, we offer alternative methods to access care, like through Teladoc. The chart below outlines where you should go for care and what it costs. To review costs for procedures and services please contact Healthcare Bluebook (see page 33).

	TELADOC	PHYSICIAN'S OFFICE	URGENT CARE	EMERGENCY ROOM (ER)
Preventive Care Annual physical, preventive exam, well-child care		✓		
Routine, Non-Emergency Care Colds, flu, asthma	✓	✓		
Dermatology Visits	✓	✓		
Mental Health Services	✓	✓		
Minor, Semi-Urgent Care Minor broken bones and minor burns		✓	✓	
Emergency Care Allergic reactions, severe broken bones, serious burns, head injuries, chest pain				✓
What You Pay (after deductible and before reaching out-of-pocket maximum)	**$40 or less** except for Teladermatology which is $75 and Mental Health visits which range from $80 to $160	**HRA1:** 10%; **HSA:** 20%; **HRA2:** 30% (when you choose an in-network provider/facility)		

And remember, regardless of the medical plan option you select, preventive care is always 100% covered by your plan.

VOLUNTARY DENTAL AND VISION COVERAGE

You have the opportunity to sign up for dental only coverage or dental with vision coverage through United Concordia Insurance Company (UCIC) and Davis Vision (a UCIC affiliate).

Enrollment

This plan is available to all retirees, your spouse/domestic partner and any dependent children up to age 26. You can enroll during the following time periods:

- within 90 days of your retirement date
- within 90 days of your COBRA coverage ending
- during Benefits Open Enrollment

To enroll, call **1-888-320-3316**.

To find a participating dentist or to see if your dentist, or amended dentist, participates, please visit www.unitedconcordia.com/dental-insurance. Select the Alliance network. Look for dentists with a square black box next to their names — these are the amended dentists.

If you do not have access to the internet, you can contact United Concordia's customer service department between 8 a.m. and 6 p.m. ET at **1-866-851-7576**. Be sure to mention that you are a Hershey retiree and that you are looking for a UCIC Alliance dentist.

	DENTAL PLAN ONLY		
PLAN PROVISION	RETIREE ONLY	RETIREE + 1	RETIREE + FAMILY
Monthly Rates	$22.17	$40.08	$71.59
Quarterly Rates	$57.81	$104.55	$186.75
Annual Rates	$226.20	$409.08	$730.32

	DENTAL PLAN WITH VISION PLAN		
PLAN PROVISION	RETIREE ONLY	RETIREE + 1	RETIREE + FAMILY
Monthly Rates	$30.16	$55.28	$94.79
Quarterly Rates	$81.78	$150.15	$256.35
Annual Rates	$322.08	$591.48	$1,008.72

DENTAL PLAN OVERVIEW

With the UCIC Flex dental plan, you can select a dental-only plan or a dental and vision plan. The dental portion of both plans offers:

- **Preventive care covered at 100%** including routine exams, cleanings and bitewing x-rays.
- **Basic care covered at 70%** including fillings, certain x-rays, simple extractions, repairs to crowns, bridges and dentures, and palliative treatments. A six-month waiting period applies when enrolling more than 90 days following retirement.
- **A discount on Major care** (Class III) such as root canals, crowns, prosthetics, non-surgical and surgical periodontics, complex oral surgery and general anesthesia, along with certain non-routine services, if provided by an Advantage Plus amended dentist. (Class III services are not insured services and therefore do not require submitting a claim.) The average discount is 31%.

Alliance Network

The dental plan gives you access to the Alliance Network, UCIC's largest dental network which includes over 97,500 dentists. Most of the dentists are "amended" network dentists because they have agreed to accept allowances for non-covered services such as Class III services (crowns, bridges, implants, etc.) at discounted rates. When you receive a Class III service from an amended Alliance dentist, you'll receive an average discount of 31%!

You can check to see if your dentist is an amended dentist or ask for a list of amended dentists in your area by calling United Concordia's customer service department at **1-866-851-7576**.

Refer to the table on the next page for more details on the dental plan design.

HERSHEY'S DENTAL PLAN FOR PRE-65 RETIREES

BENEFIT CATEGORY	RETIREE DENTAL PLAN DETAILS	
	IN-NETWORK	OUT-OF-NETWORK*
CLASS I — DIAGNOSTIC/PREVENTIVE SERVICES		
Exams; X-rays (Bitewings); Fluoride Treatments; Cleanings; Sealants	Plan pays 100% of MAC; member pays nothing	Plan pays 100% of MAC; member pays remainder of dentists charge
CLASS II — BASIC SERVICES (Six-month waiting period applies to new entrants)		
X-Rays (all others); Palliative Treatment; Basic Restorative; Space Maintainers; Simple Extractions; Repairs of Crowns, Inlays, Onlays, Bridges, Dentures	Plan pays 70% of MAC; member pays 30% of MAC	Plan pays 70% of MAC; member pays remainder of dentists charge
CLASS III — MAJOR SERVICE		
Endodontic; Inlays, Onlays, Crowns; Prosthetics; Surgical and Nonsurgical Periodontics; Complex Oral Surgery; General Anesthesia	Average discounts of 31%* off dentist's charge Must visit an amended dentist	No discount; member pays dentist's full charge
ORTHODONTICS, COSMETICS OR OTHER SERVICES		
Orthodontic Diagnostic, Active, Retention Treatment; Bleaching, Veneers, Implants	Average discounts of 31%* off dentist's charge Must visit an amended dentist	No discount; member pays dentist's full charge
Deductible (per person/per family)	$25/$75 Class I and II only	None
Out-of-Pocket Maximum	$750	None

** The average 31% discount is based on UCIC charge data. Actual discounts will vary depending upon the procedure and the geographic region in which it is performed.*

MAC = Maximum Allowable Charge

OPTIONAL VISION COVERAGE

In addition to dental benefits, Davis Vision, a UCIC affiliate, offers an optional insured vision plan that **can only be selected alongside the dental plan**. The vision plan covers the following items once every 12 months:

- Eye exam ($10 co-payment)
- One pair of eyeglasses (frames and lenses)
- Contact lenses in lieu of eyeglasses

To request a detailed information and enrollment packet for both plans, contact 1-888-320-3316.

For claims and customer service, contact United Concordia directly at 1-866-851-7576. Do not contact Hershey directly.

VISION PLAN DETAILS	
IN-NETWORK	**IN-NETWORK**
Eye Examination	Every January 1, covered in full after $10 co-payment
EYE GLASSES	
Spectacle Lenses	Every January 1, covered in full; for standard single-vision, lined bifocal, or trifocal lenses
Frames	Every January 1, covered in full; any fashion or designer frame from Davis Vision's collection* (value up to $160) OR $120 retail allowance toward any frame from provider, plus 20% off balance**
CONTACT LENSES	
Contact Lens Evaluation, Fitting & Follow Up Care	Every January 1, Davis Vision Collection Contacts, covered in full
Contact Lenses (in lieu of eyeglasses)	Every January 1, covered in full (in lieu of glasses) OR $105 retail allowance toward provider supplier contact lenses, plus 15% off balance**

** The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.*

*** Additional discounts not applicable at Walmart, Sam's Club or Costco locations.*

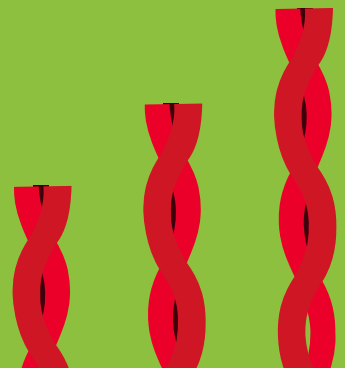
	ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS	
	WITHOUT DAVIS VISION	**WITH DAVIS VISION**
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0 – $30
Standard Anti-Reflective (AR) Coating	$83	$35
Standard Progressives (no-line bifocal)	$198	$50
Photochromic Lenses (i.e. Transitions®, etc.)*	$110	$65

** Transitions® is a registered trademark of Transitions Optical Inc.*

TAKE A *moment* TO UNDERSTAND YOUR TAX SAVINGS OPPORTUNITIES

Hershey offers several savings accounts that you can use to pay for qualified expenses. As you evaluate which medical plan option will best meet your needs, don't forget to consider the appropriate savings accounts that complement the medical option you select.

- **Health Reimbursement Account (HRA)** – for pre-65 retirees who enroll in the HRA1 or HRA2 medical plans
- **Health Savings Account (HSA)** – for pre-65 retirees who enroll in the HSA plan*



grow your accounts and take care of yourself and your family

You are responsible for determining if you are eligible for an HSA contribution and must meet the following requirements:

- Enrolled in an HSA eligible health plan
- You may not be collecting or enrolled in Medicare*
- You may not be claimed as a dependent on someone else's tax return

** Per the IRS, if you are enrolled in Medicare (even Part A) you are not eligible to contribute to or receive employer contributions to your health savings account (HSA). It is your responsibility to let the **HR Support Center** know so contributions are stopped to avoid tax consequences.*

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The HRA is a company-sponsored health benefit account that provides a company contribution annually (January) that can be applied only to eligible **medical** out-of-pocket costs. However, you will not be able to pay for any prescription drug, dental, or vision costs with the funds credited to your HRA. This account is available to retirees enrolled in the HRA1 or HRA2 plans. Retirees cannot contribute to the HRA – only Hershey may contribute post-tax funds to your account. Current tax laws allow companies to set up and fund HRAs that can then be used for health care tax-free. If the company were to provide this money in any other way to the employee – it would be taxed. Your HRA doesn't earn interest and there are no investment options, so your account will only grow with contributions from Hershey. If you do not use all the funds in one plan year, the balance will roll forward to the following plan year if you continue to enroll in an HRA eligible medical plan.

Available to retirees enrolled in:

HRA1

HRA2

HRA

CAN...

- be used for medical out-of-pocket costs
- only grow with Hershey tax-free contributions
- roll forward funds from year to year up to the deductible and rollover maximum

CANNOT...

- be used for prescription drug, dental or vision costs
- earn interest
- have investment options

WEALTH

For member questions and assistance with your HRA, contact Highmark at **1-866-763-9474** or go online and visit www.highmarkblueshield.com.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA plan is a high deductible health plan sponsored by Hershey that allows you to open and contribute to an individual, tax-advantaged savings account (i.e., an "HSA") which can be used to save for unexpected health care expenses in the current year and future medical or retiree medical expenses. The Hershey Company makes quarterly contributions to the HSA. Contributions are made at the beginning of the quarter, right after the first pay period. You can also make contributions on a pre-tax basis through payroll deduction. The funds in your account grow tax free. Hershey requires HSA plan participants to determine their employee contributions each year.

Eligible expenses include charges for services covered by the HSA plan, as well as other services that are on the IRS list of tax-deductible health care expenses available at www.irs.gov/pub/irs-pdf/p502.pdf. HSA funds used for ineligible health care expenses will be taxable and you will be subject to a 20% penalty if under age 65.

It is important to note, in the HSA plan, the deductible may be satisfied through either medical or prescription drug expenses that you incur, or a combination of the two (i.e., there are not separate deductibles for medical and prescription drugs). Fees may be charged for certain transactions (e.g., paper statements, closing your account) in your HSA account charged by Highmark and their banking partner, PNC.

Funds may not be used to cover medical expenses for dependents who are not covered under the plan or are not your tax dependents, for example, domestic partners or children who may file their own taxes. If you change medical plans or leave the company, you will still retain your full HSA balance.

For member questions and assistance with your HSA, contact Highmark at 1-866-763-9474 or go online and visit www.highmarkblueshield.com.

HOW IT WORKS:

When you have a qualified health care expense, and want to use your HSA for eligible medical expenses, you may:

- **Pay claims online** by requesting payment be made to your provider or to you. Elect to have all claims automatically submitted to your account for reimbursement.
- **Use the HSA debit card** when paying for prescriptions or when paying medical bills, just as you would use a credit card. There must be enough money in your account to cover the expense.
- **Submit a reimbursement request online or by mail** if you did not use your debit card for the purchase.

HOW THE ACCOUNTS COMPARE

	HRA	HSA
Who is eligible?	When you are enrolled in the HRA1 or HRA2 medical plan	When you are enrolled in the HSA medical plan
Who Contributes?		
– You	Retirees cannot make contributions to this account	Your maximum contributions (per year)[1]: $2,850 (individual) $5,700 (individual + 1) $5,200 (family)
– Hershey	Hershey makes an annual contribution in January of: **HRA1** $500 individual only $1,000 individual + 1 $1,500 family **HRA2** $300 individual only $600 individual + 1 $900 family	Hershey contributes to the HSA on a quarterly basis (April, July, October and December) up to a **total annual contribution** of: $750 individual only $1,500 individual + 1 $2,000 family
What can I use the account for?	IRS-approved medical expenses (does not include prescription drug, dental and vision) ***Note:*** *Your medical carrier will automatically use available funds from your HRA first to pay your claims until your balance is exhausted.*	IRS-approved health care expenses (including medical, dental, vision and prescription drugs)
Do my funds "roll-over" from year to year?	**Yes** (if you elect to continue to enroll in the HRA1 or HRA2)[2]	**Yes** (even if you choose another plan in the future)
Does my account earn interest?	**No**	**Yes** (investment options available for balances greater than $500)
Is there a debit card available for eligible expenses?	**No**	**Yes**

[1] *Because you are age 55 or older you can contribute an additional $1,000 as a "catch-up" contribution.*

[2] *You can carry over unused HRA funds from one year to the next, as long as the amount of the rollover does not exceed your medical plan's annual deductible (including the annual Hershey contribution) or the annual rollover maximum.*

HRA: *If you enroll during the year, your HRA contribution will be a prorated amount based on the number of months you're going to work.*
HSA: *If you enroll during the year, you will only receive the quarterly contributions for the remaining quarters of that calendar year.*

HOW IT WORKS:

- When you are experiencing a rare or complex condition, Highmark will review your case and submit to Best Doctors for a second expert opinion — there's nothing you have to do!
- Your case will then be matched to the most appropriate medical expert.
- An expert physician will provide a personalized response.

it's time TO REVIEW YOUR ADDITIONAL BENEFITS

Hershey proudly offers the following additional benefits to help you make the most of your medical benefits.

Best Doctors®:

This confidential and free benefit helps you and your family to make informed medical decisions, from minor surgery to serious issues like cancer, heart conditions and more.

In-Depth Medical Review — provides an extensive review of your records and tests by a nationally recognized expert when a diagnosis of a condition is in question.

Highmark will be reviewing medical cases and sending the most complex cases and rare conditions automatically to Best Doctors for expert second opinions, resulting in an easier process and less paperwork for you! For more information, discuss your unique situation with a Highmark advocate or health coach.

Highmark's Care Management Program

As part of your Highmark Blue Shield coverage you have access to one-on-one attention from your own Highmark nurse — someone to help you work better with your doctor, help you get needed follow-up care and more.

Your nurse can help you:

- Prepare for a hospital stay and follow your doctor's care plan.
- Arrange for in-home care.
- Cope with injuries from an accident.
- Handle a serious or complex condition.
- Take control of chronic health conditions such as diabetes, heart disease, asthma and more.

Call **1-866-763-9474** to get in contact with a Highmark nurse!

NAVIGATE YOUR HEALTH CARE NEEDS WITH HIGHMARK'S ADVOCACY SERVICES

Hershey understands managing your benefits and health isn't always easy. That's why you have access to a resource of trained, dedicated specialists through your medical plan provider, Highmark, at no additional cost. Highmark's advocates and health coaches will help you and your family resolve health care concerns and navigate complex health care issues by providing a single point of contact, simply call **1-866-763-9474**. Check out some of the key features and get the most out of your benefits:

- **Save money on care** — talk to Highmark's advocates to learn how to choose the most cost-effective options to receive the care you need.
- **Understand your benefits** — talk to an advocate or health coach when you have questions about your benefits and want someone to help you make the best decisions about your care.
- **Make the most of Highmark's website** — get support from Highmark's advocates to benefit from many online tools and resources to help you manage your health and become an informed health care consumer.

HIGHMARK.

FIND THE QUALITY CARE YOU DESERVE WITH HEALTHCARE BLUEBOOK

Lower quality medical care can lead to higher complications, unnecessary procedures and a higher chance of misdiagnosis – costing you more of your time and money. Healthcare Bluebook helps take the guesswork out of choosing a quality provider while also saving you money. This benefit program can help you find the highest quality care at the best value based on your specific needs. Many of your colleagues are already using Healthcare Bluebook to save on costs. Have you tried it?

How it works

- When your doctor suggests a test or procedure, (like a colonoscopy, ultrasound, or MRI/XRay for example) take a minute to do a simple search in Healthcare Bluebook for the most cost-effective provider

- Access Healthcare Bluebook online by visiting **healthcarebluebook.com/cc/Hershey** and look for the color coded cost and quality ratings, so you can easily see a side-by-side comparison of available facilities and know where to go for the highest quality at the lowest costs.

Healthcare Bluebook™

HAVE QUESTIONS ABOUT A HEALTH ISSUE?

Don't forget about Highmark's Care Management Program! Simply call **1-866-763-9474** to get in contact with a nurse. Flip to page 31 for more details on this benefit.

USE YOUR MOBILE PHONE TO ACCESS HEALTHCARE BLUEBOOK

Download the free app from the Apple App store or Google Play. Then launch the "Bluebook" app on your phone and click *My Employer Provides Bluebook*. Lastly, enter your Company Code (Hershey) and any additional login information as prompted.

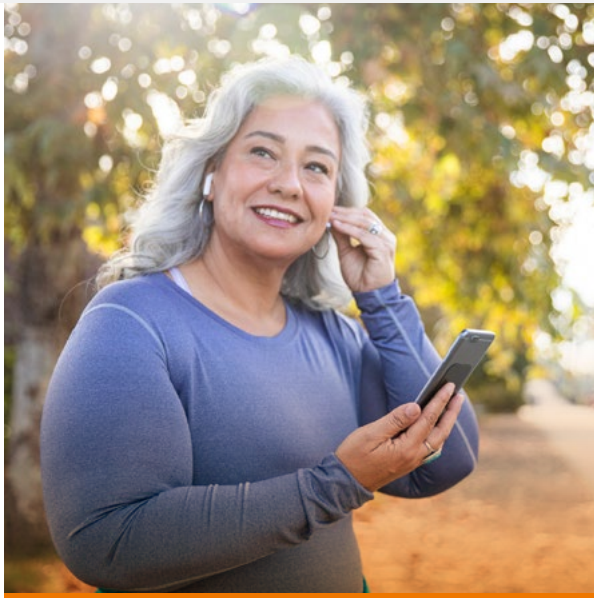
Once you've logged in, search for your procedure, review the price range shown on the color bar, then scroll down the page and review the list of facility options by quality and cost.

TAKE ADVANTAGE OF SHARECARE — YOUR DIGITAL HEALTH COMPANION

Sharecare is your interactive, digital solution to help you manage your health and support you in living a healthy lifestyle. The health management platform, offered through our medical plan administrator, Highmark Blue Shield, will meet you wherever you are on your health journey, regardless of age, gender, and health conditions. Check out the many features you can benefit from:

- **RealAge** — learn about the true age of the body you're living in by completing the unique health risk assessment which will assess your health behaviors and existing conditions.
- **Green days** — keep track of your health behaviors that affect your RealAge and use the app as a motivational tool for sustained health improvements.
- **Personalized Content** — receive personalized news, articles, videos and more based on your RealAge results and topics or conditions you care about.
- **AskMD®** — learn more about a health condition and get expert advice on when and at what level you should seek medical care with AskMD, the sound medical advice at your fingertips.

sharecare



DON'T MISS OUT!

Download the free app from the Apple App store or Google Play. Then launch the app on your phone.

COMPANY	BENEFIT	CONTACT INFORMATION
Davis Vision	Voluntary Vision Program	1-877-923-2847, client code 2231 www.davisvision.com
Express Scripts, Inc.	Prescription Drug	1-877-309-6408 www.express-scripts.com
Highmark Blue Shield	Advocacy Services Best Doctors Care Management Medical Plans - HSA & HRA Sharecare	1-866-763-9474 www.highmarkblueshield.com
Highmark Blue Shield (for Highmark participants only)	Teladoc	1-800-TELADOC (835-2362) www.teladoc.com/enter
MetLife	Retiree Life Insurance	1-866-492-6983 www.metlife.com/mybenefits
Quit for Life	Tobacco Cessation	1-866-784-8454 www.quitnow.net/hersheys

continued

COMPANY	BENEFIT	CONTACT INFORMATION
The Hershey Company	HR Support Center	1-800-878-0440 askHR@hersheys.com 8:30 a.m. - 5:00 p.m. ET, Monday through Friday www.hersheyretirees.com
United Concordia Insurance Company	Voluntary Dental Program	For enrollment questions: 1-888-320-3316 For claims questions: 1-866-851-7576 8 a.m. - 6 p.m. ET www.unitedconcordia.com/dental-insurance
WageWorks	Questions about your Retiree Medical monthly bill	1-888-678-4881 https://mybenefits.wageworks.com
Willis Towers Watson	Pension Service Center	1-888-837-2327 www.eepoint.com/Hershey

LEGAL NOTICES

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to The Hershey Company plans' regular copayments and deductibles.

If you would like more information on WHCRA benefits, call your plan administrator **1-866-763-9474**.

Special Rules Affecting Benefits: Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects how coverage is provided by The Hershey Company medical plans. This notice summarizes these rules.

Special Enrollment Periods

HIPAA also provides special enrollment rights under certain circumstances.

LOSS OF OTHER COVERAGE

If, when you first become eligible for medical coverage under a plan sponsored by The Hershey Company and you decline coverage for yourself, your spouse, or other dependents because of other medical insurance or group health plan coverage, you may be able to enroll yourself and your dependents in The Hershey Company-sponsored medical plan if you, your spouse, or your dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your spouse's or dependents' other group health coverage). However, you are responsible for requesting the change through the **HR Support Center** within 31 days after other coverage ends (or after the employer stops contributing toward the other coverage).

You may be able to enroll yourself, your spouse, or your other dependents in The Hershey Company-sponsored medical plan if you, your spouse, or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP) and that coverage ends as a result of a loss of eligibility for that coverage. However, you are responsible for requesting enrollment through the **HR Support Center** within 60 days after the termination of the Medicaid or CHIP coverage.

LEGAL NOTICES

BECOMING ELIGIBLE FOR A STATE PREMIUM ASSISTANCE SUBSIDY

You may be able to enroll yourself, your spouse, or your other dependents in a plan sponsored by The Hershey Company if you, your spouse, or your other dependent become eligible for premium assistance through either Medicaid or CHIP. See the section entitled "Employer Children's Health Insurance Plan" for further details.

ACQUIRING A NEW DEPENDENT

If you acquire a new dependent because of marriage, birth, adoption, or placement for adoption, you can request to enroll yourself and your new dependent(s) in The Hershey Company medical plan by contacting the **HR Support Center**, selecting the appropriate Qualifying Event and making election(s) within 31 days of the marriage, birth, or adoption.

The Plan's Duties with Respect to Protected Health Information

HIPAA privacy and security rules impose numerous requirements on employer health plans concerning the use and disclosure of protected health information (PHI). This is information held by such plans that may identify individuals covered under the plans and that relates to the health and related health care services received by those individuals.

These plans are required by law to uphold the privacy and security of your PHI and to provide you with a notice of their legal duties and privacy and security practices with respect to your PHI.

The notice describes how the plans may use and disclose PHI for specified purposes permitted or required by law, and also describes your rights with respect to your PHI. It is not feasible in this Notice to describe in detail all the of the specific uses and disclosures the Plan may make of PHI, so this Notice describes categories of uses and disclosures of PHI that the Plan may make and gives examples of those uses and disclosures.

A copy of the plan "Notice of Privacy Practices" is included with the Summary Plan Description you receive when you enroll in any of the above plans. If there is a material change in the privacy practices or individual rights stated in the Notice, the plans will provide you with an updated Notice. You also may obtain a copy of the Notice currently in effect by contacting the **HR Support Center**.

It is important to note that generally HIPAA privacy and security rules apply to the plans, not to The Hershey Company as an employer. Different policies may apply to other Hershey Company programs or to data unrelated to the health plan. Also note that this Notice applies only to your PHI that the Plan maintains. It does not affect your health care provider's privacy practices with respect to your PHI that they maintain.

LEGAL NOTICES

Notice of Privacy Practices

EFFECTIVE DATE

This Notice is effective September 23, 2013.

PURPOSE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Hershey Company Health & Welfare Plan (the "Plan") is regulated by numerous federal and state laws. The Health Insurance Portability and Accountability Act ("HIPAA") identifies protected health information ("PHI") and requires that the Plan maintain a privacy policy and that it provides you with this Notice of the Plan's legal duties and privacy practices. This Notice provides information about the ways your medical information may be used and disclosed by the Plan and how you may access your health information.

The health plans sponsored by Hershey comprise what is referred to in HIPAA as an "organized health care arrangement." This designation means that the plans may use and disclose PHI as permitted by HIPAA for purposes such as treatment, payment, and health care operations related to the organized health care arrangement. This Notice applies to the health plans sponsored by Hershey that comprise the "organized health care arrangement."

PHI means individually identifiable health information that is created or received by the Plan that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you; and that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. If state law provides privacy protections that are more stringent than those provided by federal law the Plan will maintain your PHI in accordance with the more stringent state law standard.

In general, the Plan receives and maintains health information only as needed for claims or Plan administration. The primary source of your health information continues to be the health care provider (for example, your doctor, dentist or hospital) that created the records. Most health benefits are administered by a third party administrator ("TPA") where the Plan sponsor does not have access to PHI.

The Plan is required to operate in accordance with the terms of this Notice. The Plan reserves the right to change the terms of this Notice. If there is any material change to the uses or disclosures, your rights, the Plan's legal duties or privacy practices, the Notice will be revised and you'll receive a copy. The new provisions will apply to all PHI maintained by the Plan, including information that existed prior to revision.

LEGAL NOTICES

USES AND DISCLOSURES PERMITTED WITHOUT YOUR AUTHORIZATION OR CONSENT

The Plan is permitted to use or disclose PHI without your consent or authorization in order to carry out treatment, payment or health care operations. Information about treatment involves the care and services you receive from a health care provider. For example, the Plan may use information about the treatment of a medical condition by a doctor or hospital to make sure the Plan is well run, administered properly and does not waste money. Information about payment may involve activities to verify coverage, eligibility, or claims management. Information concerning health care operations may be used to project future health care costs or audit the accuracy of claims processing functions.

The Plan may also use your PHI to undertake underwriting, premium rating and other insurance activities related to changing TPA contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information for underwriting purposes which include eligibility determination, calculating premiums, the application of pre-existing conditions, exclusions and any other activities related to the creation, renewal, or replacement of a TPA contract or health benefit.

The Plan may disclose health information to the TPA if the information is needed to carry out administrative functions of the Plan. In certain cases, the Plan or TPA may disclose your PHI to specific employees of Hershey who assist in the administration of the Plan. Before your PHI can be used by or disclosed to these employees, The Hershey Company must certify that the Plan documents explain how your PHI will be used; identify the employees who need your PHI to carry out their duties to administer the Plan; and, separate the work of these employees from the rest of the workforce so that the Hershey Company cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, a designated employee may have the need to contact a TPA to verify coverage status or to investigate a claim without your specific authorization.

The Plan may disclose information to the Hershey Company that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals to get a new TPA contract, or to change the Plan. For example, if The Hershey Company wants to consider adding or changing an organ transplant benefit, it may receive this summary health information to assess the cost of that benefit.

The Plan may also use or disclose your PHI for any purpose required by law, such as responding to a court order, subpoena, warrant, summons, or similar process authorized under state or federal law; for health oversight activities; pursuant to judicial or administrative proceedings; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; to comply with workers' compensation laws; to provide information about the victim of a crime if, under

LEGAL NOTICES

certain limited circumstances, the Plan is unable to obtain the person's agreement; to assist in disaster relief efforts; to report a death we believe may be the result of criminal conduct; to report criminal conduct on the premises at the Hershey Company; to coroners or medical examiners; in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime; to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and, to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

Plans are also permitted, but not required to, use or disclose PHI for the following purposes not included in this notice:

(1) Limited Data Sets - a limited data set is health information about participants that omits their name and social security number and certain other identifying information

(2) Personal Representatives - Plans can disclose PHI to personal representatives appointed by the participant or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult) to the same extent that the Plan would disclose information to the participant. The Plan may choose not to disclose information to a personal representative if it has a reasonable belief that (a) the participant may be a victim of domestic abuse by the personal representative, (b) recognizing such person as the participant's personal representative may result in harm to the participant, (c) it is not in the participants pest interest to such person as their personal representative.

The Plan may disclose medical information about you for public health activities. These activities generally include licensing and certification carried out by public health authorities; prevention or control of disease, injury, or disability; reports of births and deaths; reports of child abuse or neglect; notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. The Plan will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and the disclosure is necessary to prevent serious harm.

Uses and disclosures other than those listed will be made only with your written authorization. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions to include certain treatment, payment or health care operations); use or disclosure for marketing purposes (with limited exceptions); and disclosure in exchange for remuneration on behalf of the recipient of your protected health information.

You should be aware that the Plan is not responsible for any further disclosures made by the party to whom you authorize the release. If you provide the Plan with authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization.

LEGAL NOTICES

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the **HR Support Center**. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the **HR Support Center**.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the **HR Support Center**. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that is not part of the medical information kept by or for the Plan; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy; or is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the **HR Support Center**. Your request must state a time period of no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge.

LEGAL NOTICES

For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Effective September 23, 2013 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the **HR Support Center**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the **HR Support Center**. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

LEGAL NOTICES

Right to Obtain a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Summary of Benefits and Coverage

The Summary of Benefits Coverage (SBC) documents can be found online at **https://www.thehersheycompany.com/en_us/careers/retirees/health-insurance.html** or you may call the **HR Support Center** at **1-800-878-0440** to request a printed copy.

PLAN CONTACT INFORMATION

Information about the Plan may be obtained at any of the addresses or phone numbers below:

The Hershey Company
19 E. Chocolate Avenue
P.O. Box 810
Hershey, PA 17033-0810
1-800-878-0440

Medical Benefit Administrator:

Highmark Blue Shield
P.O. Box 890382
Camp Hill, PA 17089-0382
1-866-763-9474

Pharmacy Benefit Administrator:

Express Scripts, Inc. P.O. Box 66583
St. Louis, MO 63166
1-877-309-6408
(TDD 800-899-2114)

Contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (SPD). The Summary Plan Description and other pertinent documents can be found online at **https://www.thehersheycompany.com/en_us/careers/retirees/health-insurance.html**, or you may call the **HR Support Center** at **1-800-878-0440** to request a printed copy.

LEGAL NOTICES

Employer Children's Health Insurance Plan (CHIP)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility. The following list of states is current as of July 31, 2020.

CONTACTS		
Medicaid	Website	Phone
ALABAMA	http://myalhipp.com/	1-855-692-5447
ALASKA	The AK Health Insurance Premium Payment Program http://myakhipp.com/ Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com
ARKANSAS	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
FLORIDA	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
GEORGIA	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Click on Health Insurance Premium Payment (HIPP)	1-678-564-1162 ext. 2131
INDIANA	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: http://www.indianamedicaid.com	**Healthy Indiana Plan for low-income adults 19-64:** 1-877-438-4479 **All other Medicaid:** 1-800-403-0864
IOWA	http://dhs.iowa.gov/hawk-i	1-800-257-8563
KANSAS	http://www.kdheks.gov/hcf/	1-785-296-3512
KENTUCKY	https://chfs.ky.gov	1-800-635-2570

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CONTACTS		
Medicaid	Website	Phone
LOUISIANA	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	1-888-695-2447
MAINE	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003 **TTY:** Maine relay 711
MINNESOTA	https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
MISSOURI	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
MONTANA	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
NEBRASKA	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 **Lincoln:** 1-402-473-7000 **Omaha:** 1-402-595-1178
NEVADA	http://dhcfp.nv.gov	1-800-992-0900
NEW HAMPSHIRE	https://www.dhhs.nh.gov/oii/hipp.htm	1-603-271-5218 **Hotline: NH Medicaid Service Center:** 1-800-852-3345 ext. 5218
NEW YORK	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
NORTH CAROLINA	https://medicaid.ncdhhs.gov/	1-919-855-4100

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CONTACTS		
Medicaid	Website	Phone
NORTH DAKOTA	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
OREGON	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
PENNSYLVANIA	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
RHODE ISLAND	http://www.eohhs.ri.gov/	1-855-697-4347 1-401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA	https://www.scdhhs.gov	1-888-549-0820
SOUTH DAKOTA	http://dss.sd.gov	1-888-828-0059
TEXAS	http://gethipptexas.com	1-800-440-0493
VERMONT	http://www.greenmountaincare.org/	1-800-250-8427
WASHINGTON	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	1-800-562-3022 ext. 15473
WEST VIRGINIA	http://mywvhipp.com/	1-855-MyWVHIPP (1-855-699-8447)
WYOMING	https://wyequalitycare.acs-inc.com	1-307-777-7531

continued

Medicaid & CHIP		
COLORADO	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus	**Health First Colorado Member Contact Center:** 1-800-221-3943/State Relay 711 **CHP+ Customer Service:** 1-800-359-1991/ State Relay 711
MASSACHUSETTS	http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-862-4840
NEW JERSEY	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	**Medicaid:** 609-631-2392 **CHIP:** 1-800-701-0710
OKLAHOMA	http://www.insureoklahoma.org	1-888-365-3742
UTAH	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	1-877-543-7669
VIRGINIA	Medicaid: https://www.coverva.org/medicaid/ HIPP: https://www.coverva.org/hipp/	**Medicaid:** 1-800-432-5924 **HIPP:** 1-855-242-8282
WISCONSIN	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Don't Forget... Benefits Open Enrollment starts **Wednesday, October 28 and ends Wednesday November 11, 2020.** Take action to get the coverage you want for 2021!

All benefits are governed by plan documents. If any conflicts arise between this communication and any plan document, the plan document will prevail. Hershey and designated benefit plan administrators reserve the right to determine eligibility, to interpret, and to administer issues under the benefit programs. The Company reserves the right to amend or terminate benefit plans at any time.