



2023 Benefits Guide

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U.S. PRE 65 RETIREES





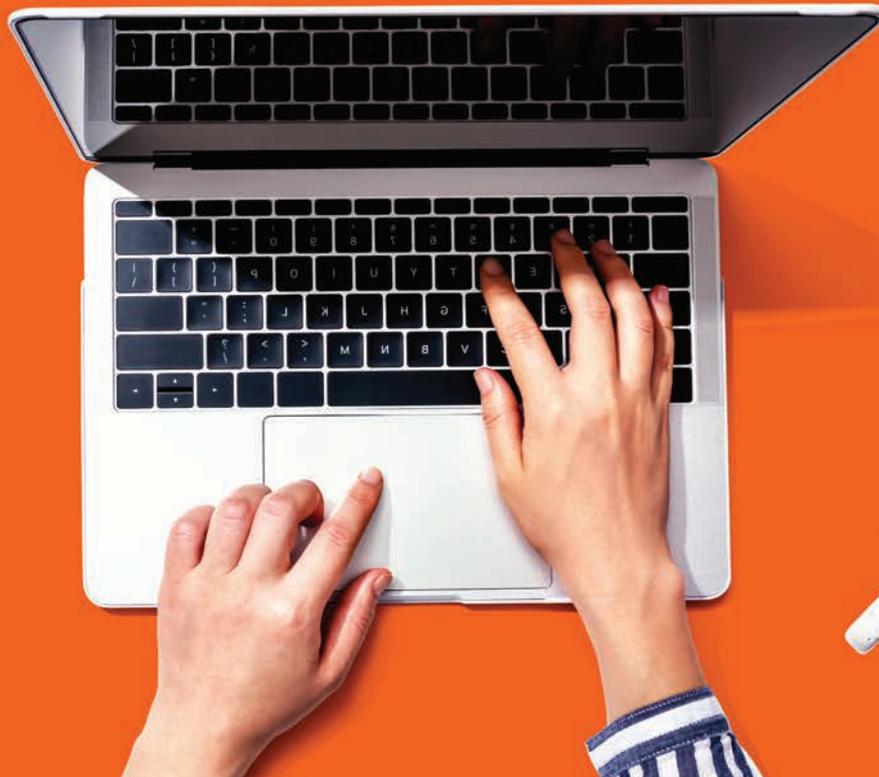
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HOW TO NAVIGATE THIS GUIDE

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- 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



LOOKING FOR SOMETHING?

- 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.
- 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).

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.



Welcome

The Hershey Company takes pride in offering a benefits program that provides a wide range of quality programs and valuable options to help you be well and plan for a healthy future.

Benefits Open Enrollment is a good time to take a fresh look at your (and your family's) health care costs from 2022 and think about your expected health care needs for 2023.

Explore this guide to learn more about your benefit options, so you can make thoughtful health care decisions to get the coverage that is best suited to the unique needs of you and your family.



What You Need To Know

WHAT'S NEW FOR 2023?

- **Introducing the new HRA3 medical plan** which features low monthly premiums but much higher deductibles. This plan may make sense for those with low health care needs who only want to protect themselves from worst case scenarios, like getting seriously sick or injured.
- **New digital musculoskeletal program Well360 Motion** through Sword Health for medical plan members.
- **Diabetes medication and supplies** covered at 100%.

REVIEW YOUR BENEFITS ENROLLMENT STATEMENT

Review your Benefits Enrollment Statement, scheduled to mail in mid-October, to see the cost of each medical plan option.

REVIEW AND UPDATE YOUR DEPENDENT INFORMATION

If you need to add a dependent to your coverage for 2023, you must contact the HR Support Center at askHR@hersheys.com or call **1-800-878-0440** and submit the required documentation (e.g., social security number, birth or marriage certificate) before coverage begins. Failure to provide documentation could result in a delay and 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.

BILLING FOR MEDICAL & COBRA

HealthEquity/WageWorks is responsible for the billing administration for retiree medical and COBRA on behalf of The Hershey Company.

Submit premium payments three ways:

1. Visit mybenefits.wageworks.com to make one-time payments each month or set up recurring payments. Payments made by Electronic Funds Transfer (EFT) will be withdrawn between the 26th and 29th of the month prior to the due date.
2. Call the 24/7 HealthEquity/WageWorks interactive phone system at **1-888-678-4881**.
3. Mail payments, payable to WageWorks, to:
WageWorks, Inc.
P.O. Box 660212
Dallas, TX 75266-0212

Questions?

Call HealthEquity/WageWorks at **1-888-678-4881**, 8 a.m. to 8 p.m. ET, Monday through Friday.

Eligibility

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

- 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

DOMESTIC PARTNERS

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.



WILL YOUR CHILD AGE OUT OF COVERAGE?

Your dependent child becomes ineligible for coverage under your Hershey benefit plan on their 26th birthday. 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](https://www.healthcare.gov), or by contacting the HR Support Center at 1-800-878-0440 or askHR@hersheys.com.



Qualifying Life Events

Once you make your benefits election for 2023, they will remain in effect for the full calendar year (January 1 through December 31) per IRS regulations, unless you experience a qualifying life event, including:

- 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

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 askHR@hersheys.com and provide any required supporting documentation. Any benefit change requested must be consistent with your qualified life event. 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.



Benefits Open Enrollment

Benefits Open Enrollment begins Wednesday, October 26 and ends at 11:59 pm ET Wednesday, November 9. Your elections will go into effect January 1, 2023.

IF YOU TAKE NO ACTION...

Your 2022 elections will roll over to 2023, and you will keep the medical plan coverage and the enrolled dependents you have now.

YOU MUST TAKE ACTION IF...

- You want to make any changes to your health insurance options
- You want to add or remove any dependents from coverage
- You want to make 2023 contributions into a Health Savings Account

HOW TO ENROLL

Mark your selections on the Benefits Enrollment Statement and postmark it no later than November 9, 2022, to:

The Hershey Company
HR Support Center
19 East Chocolate Ave.
Hershey, PA 17033

Be sure to make a copy of the Benefits Enrollment Statement for your records.

AFTER BENEFITS OPEN ENROLLMENT CLOSES

1. If you make a change to your benefits for 2023, you will receive a Benefits Confirmation Statement in early December. Check your statement carefully to make sure it reflects the appropriate changes. If you see an error, contact the HR Support Center at askHR@hersheys.com or **1-800-878-0440** immediately.
2. 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.

NEED HELP?

Contact the HR Support Center at askHR@hersheys.com or call **1-800-878-0440**, 8:30 a.m. - 5:00 p.m. ET, Monday through Friday.

The elections you make (or roll over) during this year's Benefits Open Enrollment will be effective for the entire 2023 calendar year. You will not be able to change your elections until the next Benefits Open Enrollment period unless you experience a qualifying life event.



Medical

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 2023, you will see a new medical plan option called HRA3, which is a low cost medical plan with a lower level of benefits when you are paying for care. You'll also see a modest increase in contributions that is consistent with the expected cost increase for health care services in the U.S.

HRA1

All four 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).

HSA

HRA2

The plans differ by giving you a choice of the amount you pay monthly for coverage and your cost when you receive care. All four options offer different contributions, deductibles and out-of-pocket maximums. As you evaluate which medical plan option will best meet your needs, don't forget to consider the appropriate tax-advantaged accounts that complement the medical option you select.

HRA3

NOTE: For more details about the medical plan options, access the Summary of Benefits and Coverage (SBC). The SBCs can help you choose a medical plan and show you how you would share the cost for covered health care services. The SBC documents can be found at hersheycompany.com/en_us/home/retirees/health-insurance.html.





HOW HEALTH CARE COST SHARING WORKS

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.

HERE'S HOW IT 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".

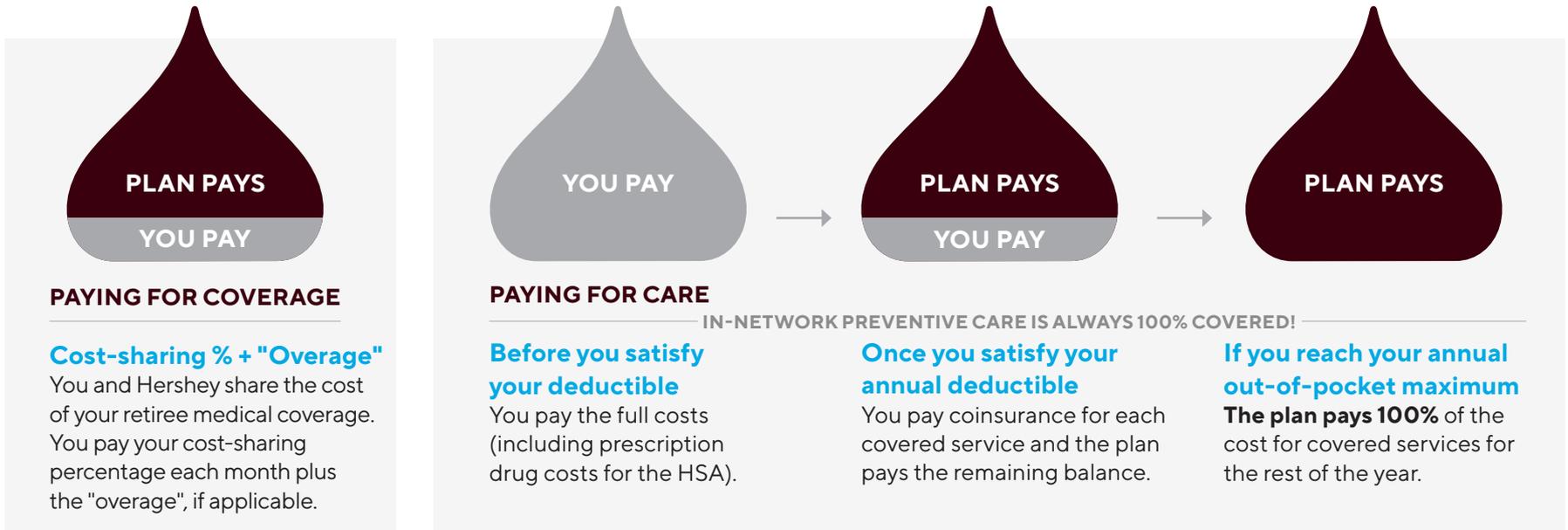
The monthly costs for 2023 are set based on previous claims experience. Therefore, there is no additional monthly overage for pre-65 retirees in 2023. You will only pay your monthly amount as referenced on your Benefits Enrollment Statement.

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.



HOW THE MEDICAL PLAN WORKS

Regardless of which plan you choose; they generally work the same way.



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.

* Highmark Blue Shield will automatically use available funds from your HRA first to pay for medical claims and services, until your balance is exhausted.

Hershey understands that it can be challenging to pick the right medical coverage. While our four 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 THE MEDICAL PLAN WORKS

Each of our medical plans is paired with a tax-advantaged savings account – **Health Reimbursement Account (HRA)** or **Health Savings Account (HSA)** – you can use to pay for eligible out-of-pocket expenses. Regardless of which plan you select, Hershey will make a contribution to your account.

	MEDICAL PLAN OPTIONS			
	HRA1	HSA	HRA2	HRA3
Type of account available	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	Health Reimbursement Account (HRA)	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	\$100 ¹ individual only \$200 ¹ individual + 1 \$300 ¹ family
Retiree contributions	Retiree cannot make contributions to the HRA.	Your Maximum Contribution (per year): \$3,100 individual only \$6,250 individual + 1 \$5,750 family	Retiree cannot make contributions to the HRA.	Retiree cannot make contributions to the HRA.
Catch-up contribution	Not applicable	Because you are age 55 or older, you can contribute an additional \$1,000	Not applicable	Not applicable

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 are hired, or 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 and October) up to the annual contribution level. For example, if you select the HSA plan with family coverage on January 1, you will receive four quarterly \$500 contributions for a total Hershey annual contribution of \$2,000.

MEDICAL PLAN BENEFITS AT-A-GLANCE

PLAN FEATURES	MEDICAL PLAN OPTIONS							
	HRA1		HSA		HRA2		HRA3	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible								
Individual:	\$1,500	\$2,250	\$1,750	\$3,500	\$1,750	\$3,500	\$3,500	\$7,000
Individual + 1 & Family:	\$3,000	\$4,500	\$3,500	\$7,000	\$3,500	\$5,850	\$7,000	\$14,000
Coinsurance (Plan pays)	90%	70%	80%	60%	70%	50%	70%	50%
Annual OOPM								
Individual:	\$2,200	\$4,400	\$2,500	\$5,000	\$3,000	\$6,000	\$6,000	\$12,000
Individual + 1 & Family:	\$4,400	\$8,800	\$5,000	\$10,000	\$6,000	\$12,000	\$12,000	\$24,000
Deductible and OOPM Type	Embedded		Aggregate		Embedded		Embedded	
Preventive Care (no deductible)	100%	70%*	100%	60%*	100%	50%*	100%*	50%*
Office Visits	90%	70%*	80%	60%*	70%	50%*	70%*	50%*
Urgent Care	90%	90%*	80%	80%*	70%	70%*	70%*	70%*
Emergency Care	90%	90%*	80%	80%*	70%	70%*	70%*	70%*

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 9](#), if applicable.

Note: Refer to [page 13](#) for definitions of aggregate versus embedded deductibles.

* Out-of-network reimbursement levels will vary. Reimbursement for in-area out-of-network providers is based on an adjusted contractual allowance for similar services from an in-area in-network provider. Reimbursement for out-of-area out-of-network providers is based on the Blue Cross Blue Shield Association (BCBSA) local licensees' pricing.



Key Terms

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 (coinsurance) and when the plan starts paying the full expenses of covered 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. Once two or more family members meet the family limits, the plan begins paying its share for all covered family members.
- **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.



Preventive Care

Preventive care, including annual physicals, gynecological annual exams, mammograms, colonoscopies, age/gender appropriate screenings, well child visits and immunizations, is key to avoiding potential serious health conditions.

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

For the most up to date list of covered preventive care services, visit www.highmarkblueshield.com or call Highmark at 1-866-763-9474.



GET THE RIGHT CARE

Hershey medical plans cover eligible services from a variety of providers and facilities, including alternative methods like Teladoc. Be sure to use [Healthcare Bluebook](#) to review the cost of services and procedures.

	TELADOC	PHYSICIAN'S OFFICE	URGENT CARE	EMERGENCY ROOM (ER)
<p>The preventive exam will help you and your doctor to get a screenshot of your health and uncover potential health concerns. Plus, you will earn an incentive for your HRA/HSA.</p> <p>Preventive Care Annual physical, preventive exam, well-child</p> <p>ALWAYS 100% COVERED</p>		✓		
<p>Routine, Non-Emergency Care Colds, flu, asthma</p>	✓	✓		
<p>Dermatology Visits</p>	✓	✓		
<p>Mental Health Services</p>	✓	✓		
<p>Minor, Semi-Urgent Care Minor broken bones and minor burns</p>		✓	✓	
<p>Emergency Care Allergic reactions, severe broken bones, serious burns, head injuries, chest pain</p>				✓
<p>What You Pay (after deductible and before reaching out-of-pocket maximum)</p>	<p>\$55 except for Teledermatology which is \$75 and Mental Health visits which range from \$95 to \$220</p>		<p>HRA1: 10% after deductible; HSA: 20% after deductible; HRA2: 30% after deductible; HRA3: 30% after deductible (when you choose an in-network provider/facility)</p>	

Medical Plan Resources

TELADOC

Teladoc provides 24/7 virtual access to U.S. board-certified physicians for non-emergency health care, advice and prescription medications, when appropriate. You can talk with a doctor 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.

Teladoc is an easy way to get care for non-emergency issues, including:

General medicine

- Sore throats
- Allergies
- Cold/Flu
- Ear infections
- Respiratory problems

Teledermatology

- Acne
- Rash
- Shingles

Behavioral Health

- Depression
- Anxiety
- Family difficulties

Eligibility

You must be a Hershey medical plan participant in order to receive services through Teladoc.

Costs

• Consultations (vary based on level of service):

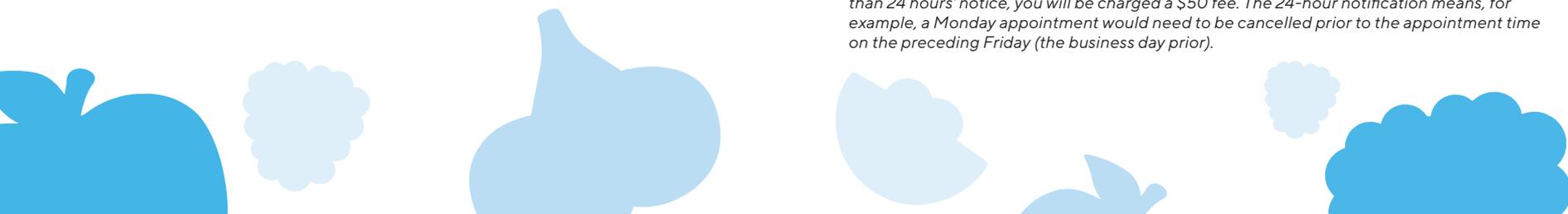
- General medicine: \$55
- Teledermatology: \$75
- Behavioral Health: \$95 to \$220

- **Prescriptions:** You will be required to pay for any prescriptions you receive through Express Scripts.

Get started

Important! You need to register before you can use Teladoc services. Visit www.teladoc.com/enter or call 1-800-835-2362.

Please know that if you miss a scheduled mental health counseling visit or cancel with less than 24 hours' notice, you will be charged a \$50 fee. The 24-hour notification means, for example, a Monday appointment would need to be cancelled prior to the appointment time on the preceding Friday (the business day prior).





ATLAS ADVOCACY SERVICES

Highmark Atlas Advocates are your single source for all health care coverage matters. They can help you and your family navigate and resolve health care concerns and issues.

Your Atlas Advocate can provide fast, efficient service to get the answers you need. They can help you:

- Arrange a provider appointment.
- Choose the most cost-effective options.
- Find answers to your benefits questions so you can make the best decisions about your care.
- Learn more about Hershey's other benefit offerings and even connect you in real-time with the appropriate benefit company.

For more information, visit highmarkblueshield.com or call 1-866-763-9474.



CARE MANAGEMENT

Get 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.

For more information, visit highmarkblueshield.com or call 1-866-763-9474.

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.

When you are experiencing a rare or complex condition, Highmark will review your case and submit your records and tests to Best Doctors for a second expert opinion. Your case will then be matched to the most appropriate medical expert who will provide a personalized response.

For more information, visit highmarkblueshield.com or call 1-866-763-9474.

WELL360 MOTION

★**NEW** Well360 Motion, powered by SWORD, provides treatment for all musculoskeletal issues, including back, neck, shoulder, elbow, lower back, hip, wrist, hand, knee, ankle and joint. You’ll get full access to your own physical therapist, a kit that will include a tablet with wearable sensors, a personalized therapy program, and access to educational resources within the app. Your therapist will provide you with instruction and real-time feedback, so you know you are doing the exercises correctly.

Most members begin to feel relief from pain and improved mobility in a few weeks. On average, members have a 62% reduction in pain and a 60% reduction in surgery intent.

For more information, visit join.swordhealth.com/blueshield.





DIGITAL HEALTH COMPANION

Sharecare is your interactive, digital solution to help you manage your health and support you in living a healthy lifestyle. Highmark Blue Shield's health management platform will meet you wherever you are on your health journey, regardless of age, gender, and health conditions.

- **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.

Get started today! Download the free app from the Apple App store or Google Play.



HEALTHCARE BLUEBOOK

Find the highest quality care at the best value based on your specific needs. 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.

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 at 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 - Doctor Quality can help you find which doctors are the best choice for a specific procedure, whether that's your current doctor or a new high-quality physician. With a quick search and simple color symbols, you'll see quality rankings for doctors by specialty and procedure.

COST RATINGS	 At or Below Fair Price	 Slightly Above Fair Price	 Highest Price
QUALITY RATINGS	 Highest Quality	 Average Quality	 Lowest Quality

DOWNLOAD THE HEALTHCARE BLUEBOOK APP

1. Download the free app from the Apple App store or Google Play.
2. Launch the “Bluebook” app and click My Employer Provides Bluebook.
3. Enter your Company Code (Hershey) and any additional login information.

Prescription Drug Coverage

When you enroll in a Hershey medical plan option, you are automatically enrolled in prescription drug coverage through Express Scripts. You will receive a separate prescription drug ID card.

It is important to note, in the HSA plan, the deductible is made up of a combination of medical and prescription costs. For prescriptions, you 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.

IN-NETWORK	PRESCRIPTION DRUGS			
	HRA1	HSA	HRA2	HRA3
Annual Deductible	No deductible	Deductible is made up of a combination of medical and prescription costs	No deductible	No deductible
Generic Coinsurance	80% Company 20% Retiree	80% Company 20% Retiree	80% Company 20% Retiree	80% Company 20% Retiree
Brand Name Coinsurance	60% Company 40% Retiree	60% Company 40% Retiree	60% Company 40% Retiree	60% Company 40% Retiree
Out-of-Pocket Maximums	Retiree: \$1,500 Family: \$3,000 <i>(Separate from medical plan)</i>	Included under medical plan out-of-pocket maximum	Retiree: \$1,500 Family: \$3,000 <i>(Separate from medical plan)</i>	Retiree: \$1,500 Family: \$3,000 <i>(Separate from medical plan)</i>
Women's Health, Preventive Medications, Certain Generic and OTC Products, Smoking Cessation	100% coverage <i>No copay; no coinsurance</i>	100% coverage <i>No copay; no coinsurance</i>	100% coverage <i>No copay; no coinsurance</i>	100% coverage <i>No copay; no coinsurance</i>

Note: If you purchase a brand-name drug that is not specified by your doctor as dispense as written (DAW) or when a generic is available, you will pay the difference between the brand name and the generic PLUS your 40% 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.



EXPRESS SCRIPTS SELECT HOME DELIVERY

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. You'll often pay less for a 90-day supply of your medication than you'd pay at a retail pharmacy.

You must contact Express Scripts and indicate a choice. Otherwise, you will pay 100% of the 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.

Register at [Express-Scripts.com](https://www.express-scripts.com). Be sure to have your member ID number, which is on the front of your ID card, or Social Security number ready.

ACCREDO SPECIALTY PHARMACY

If you use specialty medications, which are drugs used to treat complex conditions such as cancer or rheumatoid arthritis, Accredo can provide you 24/7 access to specialty-trained pharmacists and nurses. They can also arrange delivery on any scheduled day, Monday through Friday, at no additional charge.

Learn more at www.accredo.com or call 1-844-818-8978.

DIABETES MEDICATIONS AND SUPPLIES

★ **NEW** All diabetes medications and supplies (insulins, diabetic medications, diabetes supplies, glucose meters, lancet devices, etc.) will be 100% covered and provided at no cost to you.

Learn more at [Express-Scripts.com](https://www.express-scripts.com).

SPECIALTY PHARMACY COPAY ASSISTANCE

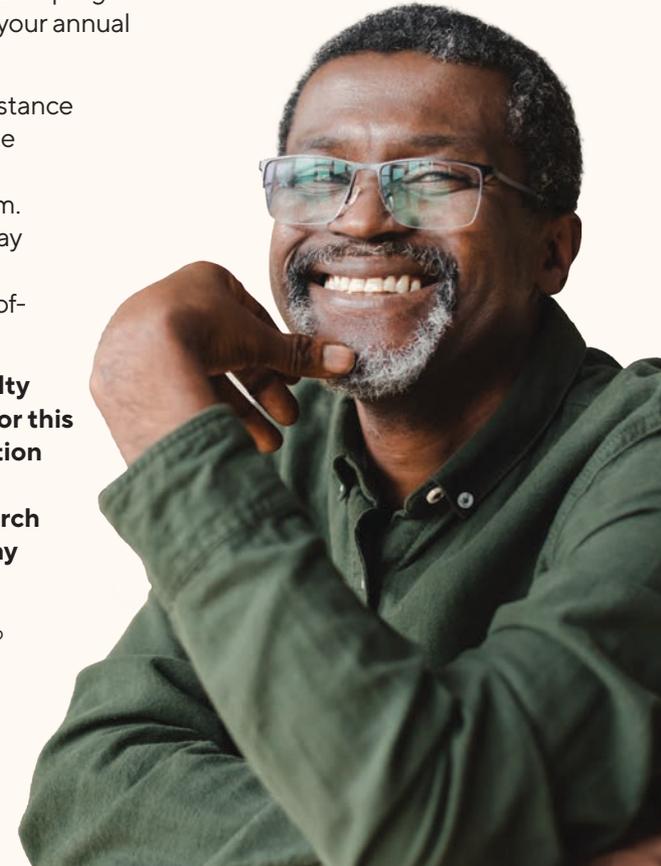
Hershey's specialty pharmacy copay assistance program* can help offset the cost of select specialty pharmacy medications. If you enroll the cost of the medication will be covered by the manufacturer at no cost to you.

If you are enrolled in the HSA plan, you may not enroll in the specialty pharmacy copay assistance program until you have satisfied your annual deductible.

Also, manufacturer assistance 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 [HR Portal](#) 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.



Dental And Vision

The Hershey Company offers you a dental plan with an optional vision plan add-on. The program is administered by United Concordia (UCCI) and Davis Vision (a UCCI affiliate). **The vision plan can only be selected alongside the dental plan.**

This plan is available to all retirees, your spouse/domestic partner and any dependent children under the age of 26.

You can enroll:

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

Learn More & Enroll

Call UCCI directly at **1-888-320-3316** to enroll or request an enrollment packet with more information.

DENTAL COVERAGE

- Preventive Services covered at 100% including routine exams, cleanings and bitewing x-rays.
- Basic Services covered at 70% including fillings, certain x-rays, simple extractions, repairs to crowns, bridges and dentures, and palliative treatments. There is a six-month waiting period for these services if you enroll more than 90 days following retirement.
- Major Services discount (average discount is 31%) including root canals, crowns, prosthetics, non-surgical and surgical periodontics, complex oral surgery and general anesthesia, along with certain non-routine services.

VISION COVERAGE

Once every 12 months, the vision plan covers:

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

	DENTAL PLAN ONLY			DENTAL PLAN WITH VISION PLAN		
	RETIREE ONLY	RETIREE + 1	RETIREE + FAMILY	RETIREE ONLY	RETIREE + 1	RETIREE + FAMILY
Monthly Rates	\$23.10	\$41.75	\$74.58	\$31.09	\$56.95	\$97.78
Quarterly Rates	\$60.21	\$108.90	\$194.55	\$84.18	\$154.50	\$264.15
Annual Rates	\$235.68	\$426.12	\$760.80	\$331.56	\$608.52	\$1,039.20

RETIREE DENTAL PLAN DETAILS

The dental plan gives you access to UCCI’s largest dental network which includes over 97,500 dentists. Most of the dentists are “amended” network dentists.

Visit unitedconcordia.com/find-a-dentist, enter your zip code and select the Alliance network. Or, call United Concordia at **1-866-851-7576** and mention you are a Hershey retiree looking for a UCCI Alliance dentist.

RETIREE DENTAL PLAN DETAILS		
	IN-NETWORK	OUT-OF-NETWORK
Deductible (per person/per family)	\$25/\$75 Class I and II only	None
Out-of-Pocket Maximum	\$750	None
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 dentist’s charge
CLASS II – BASIC SERVICES*		
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 dentist’s charge
CLASS III – MAJOR SERVICE		
Endodontic; Inlays, Onlays, Crowns; Prosthetics; Surgical and Nonsurgical Periodontics; Complex Oral Surgery; General Anesthesia	Average discounts of 31%** when you 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%** when you visit an amended dentist	No discount; member pays dentist’s full charge

* There is a six-month waiting period for these services if you enroll more than 90 days following retirement.

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

MAC = Maximum Allowable Charge



VISION PLAN DETAILS

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

VISION PLAN DETAILS	
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.

Tax-Savings Accounts

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The HRA is an employer-sponsored, tax-advantaged account that provides a company contribution annually (January) that can be applied only to eligible medical out-of-pocket costs.

Eligible expenses

- You can cover eligible medical out-of-pocket costs with the funds credited to your HRA.
- The HRA **cannot cover** any prescription drug, dental or vision costs.

Eligibility

- This account is available to retirees enrolled in the HRA1, HRA2 or HRA3 plans.

Contributions

- Only Hershey contributes funds to your account:

	HRA1	HRA2	HRA3
Individual:	\$500	\$300	\$100
Individual + 1:	\$1,000	\$600	\$200
Family:	\$1,500	\$900	\$300

- Retirees cannot make contributions to the HRA.

How it works

- Your HRA grows with contributions from Hershey. Your HRA doesn't earn interest and there are no investment options.

Rules

- If you do not use all the funds in one plan year, the balance will roll forward, up to the medical plan's deductible based on the tier level you are enrolled in as long as you continue to be enrolled in one of the HRA plans.

Manage your account

For assistance with your HRA, contact Highmark at 1-866-763-9474 or visit www.highmarkblueshield.com.





HEALTH SAVINGS ACCOUNT (HSA)

The HSA is an individual, tax-advantaged account that is paired with Hershey's HSA medical plan (high deductible health plan). You can use the funds to pay for eligible health care expenses in the current year and future years.

The funds in your account go in tax-free, grow tax-free (investment options available for balances greater than \$500), and are spent tax-free. And, even if you change medical plans or leave the company, funds in the HSA are always yours.

Eligible expenses

- Services covered by the HSA medical plan and on the [IRS list of tax-deductible health care expenses](#).

Eligibility

You are responsible for determining if you are eligible.

You must meet the following requirements:

- Enrolled in an HSA eligible medical plan,
- Not collecting or enrolled in Medicare*, and
- Not claimed as a dependent on someone else's tax return

Contributions

- The Hershey Company makes an annual contribution on a quarterly basis (January, April, July and October) of up to:
Individual: \$750 | **Individual + 1:** \$1,500 | **Family:** \$2,000
- You can also make contributions on a pre-tax basis up to:
Individual: \$3,100 | **Individual + 1:** \$6,250 | **Family:** \$5,750

Because you are age 55 or older, you can make a \$1,000 "catch-up" contribution election during Benefits Open Enrollment.

** 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 HSA. It is your responsibility to let the HR Support Center know so contributions are stopped to avoid tax consequences.*

How it works

- HSA debit card: Use the debit card when paying for medical bills or prescriptions. There must be enough money in your account to cover the expense.
- Online: Pay claims online by requesting payment be made to your provider or to you. You can elect to have all claims automatically submitted to your account for reimbursement.
- Mail: You can also submit a reimbursement request by mail.
- Please note: There can be fees associated with certain transactions (e.g., paper statements) in your HSA charged by Highmark and their account custodian, WealthCare Saver.

Rules

- You must elect HSA contributions each year.
- 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.
- HSA funds used for ineligible expenses will be taxable and you will be subject to a 20% penalty if under age 65.

Manage your account

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

HOW THE TAX-SAVINGS ACCOUNTS COMPARE

	HRA	HSA																
Who is eligible?	HRA1, HRA2 or HRA3 medical plan participants	HSA medical plan participants																
How much can you contribute?	You cannot make contributions to this account.	You can contribute up to: Individual: \$3,100 Individual + 1: \$6,250 Family: \$5,750 Age 55 and older: Can contribute an additional \$1,000																
How much does Hershey contribute?	Hershey makes an annual contribution in January of: <table border="1" data-bbox="618 785 1062 928"> <thead> <tr> <th></th> <th>HRA1</th> <th>HRA2</th> <th>HRA3</th> </tr> </thead> <tbody> <tr> <td>Individual:</td> <td>\$500</td> <td>\$300</td> <td>\$100</td> </tr> <tr> <td>Individual + 1:</td> <td>\$1,000</td> <td>\$600</td> <td>\$200</td> </tr> <tr> <td>Family:</td> <td>\$1,500</td> <td>\$900</td> <td>\$300</td> </tr> </tbody> </table>		HRA1	HRA2	HRA3	Individual:	\$500	\$300	\$100	Individual + 1:	\$1,000	\$600	\$200	Family:	\$1,500	\$900	\$300	Hershey makes an annual contribution on a quarterly basis (January, April, July and October) of up to: Individual: \$750 Individual + 1: \$1,500 Family: \$2,000
	HRA1	HRA2	HRA3															
Individual:	\$500	\$300	\$100															
Individual + 1:	\$1,000	\$600	\$200															
Family:	\$1,500	\$900	\$300															
What can I use the account for?	IRS-approved medical expenses	IRS-approved health care expenses																
Do my funds “roll-over” from year to year?	Yes (if you remain a HRA1, HRA2 or HRA3 medical plan participant)	Yes (even if you choose another plan in the future)																
Does my account earn interest?	No	Yes																
Is there a debit card available?	No	Yes																

HRA: If you enroll during the year, your contribution will be a prorated amount based on the remaining number of months.

HSA: If you enroll during the year, you will only receive the quarterly contributions for the remaining quarters of the year.



COMPANY	BENEFIT	CONTACT INFORMATION
Davis Vision	Voluntary Vision Program	1-877-923-2847, client code 2231 www.davisvision.com
Express Scripts, Inc. Accredo	Prescription Drug Specialty Prescription Drugs	1-877-309-6408 www.express-scripts.com 1-844-818-8978
HealthEquity/WageWorks	Retiree Medical monthly bill	1-888-678-4881 https://mybenefits.wageworks.com
Highmark Blue Shield	Atlas Advocacy Services Best Doctors Care Management Medical Plans – HSA & HRA Sharecare Well360Motion by SWORD	1-866-763-9474 www.highmarkblueshield.com
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
Teladoc	Telemedicine	1-800-835-2362 www.teladoc.com/enter
The Hershey Company	HR Support Center	1-800-878-0440 askHR@hersheys.com
United Concordia	Voluntary Dental Program	For enrollment: 1-888-320-3316 For claims: 1-866-851-7576 www.unitedconcordia.com/dental-insurance
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.

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 or lose eligibility for premium assistance through either Medicaid or CHIP. You must request enrollment within 60 days of the event. 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.



Note: Due to the impact of the National Emergency resulting from the COVID-19 outbreak, the federal government has extended certain deadlines for employee benefit plans. Effective March 1, 2020, all group health plans, such as The Hershey Company-sponsored medical plan, are required to suspend certain employee benefit plan deadlines until the earlier of: (i) one year from the date the deadline would have begun running for an individual, or (ii) the end of the “Outbreak Period”. The “Outbreak Period” is defined as March 1, 2020, until 60 days after the announced end of the COVID-19 National Emergency or such other date as announced by the federal government. The extended timeframes apply to the above 31 days and 60 days periods.

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.

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.

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 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 participant's best 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.

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.

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.

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.

Summary of Benefits and Coverage

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



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, 2022.

MEDICAID	WEBSITE	PHONE
ALABAMA	http://myalhipp.com/	1-855-692-5447
ALASKA	http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx Email: CustomerService@MyAKHIP.com	1-866-251-4861
ARKANSAS	http://myarhipp.com/	1-855-MyARHIP (855-692-7447)
CALIFORNIA	http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	1-916-445-8322



MEDICAID	WEBSITE	PHONE
FLORIDA	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
INDIANA	Low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	Low-income adults 19-64: 1-877-438-4479 All other Medicaid: 1-800-457-4584
KANSAS	https://www.kancare.ks.gov/	1-800-792-4884
KENTUCKY	KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPPPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Medicaid: https://chfs.ky.gov	KI-HIPP: 1-855-459-6328 KCHIP: 1-877-524-4718
LOUISIANA	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
MAINE	https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003/Maine Relay 711 1-800-977-6740/Maine relay 711
MINNESOTA	https://mn.gov/dhs/people-we-serve/children-and-families/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 Email: HSHIPPProgram@mt.gov	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://dhcftp.nv.gov	1-800-992-0900



MEDICAID	WEBSITE	PHONE
NEW HAMPSHIRE	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	1-603-271-5218 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
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/Services/Assistance/Pages/HIPP-Program.aspx	1-800-692-7462
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	https://www.hca.wa.gov/	1-800-562-3022
WYOMING	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269



MEDICAID & CHIP	WEBSITE	PHONE
COLORADO	Health First Colorado: https://www.healthfirstcolorado.com CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	Health First Colorado: 1-800-221-3943/State Relay 711 CHP+: 1-800-359-1991/State Relay 711 HIBI: 1-855-692-6442
GEORGIA	HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	HIPP: 1-678-564-1162, Press 1 CHIPRA: 1-678-564-1162, Press 2
IOWA	Medicaid: https://dhs.iowa.gov/ime/members Hawki: http://dhs.iowa.gov/Hawki HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
MASSACHUSETTS	https://www.mass.gov/masshealth/pa	1-800-862-4840
NEW JERSEY	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 1-609-631-2392 CHIP: 1-800-701-0710
OKLAHOMA	http://www.insureoklahoma.org	1-888-365-3742
RHODE ISLAND	http://www.eohhs.ri.gov/	1-855-697-4347 1-401-462-0311 (Direct Rite Share Line)
UTAH	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
VIRGINIA	Medicaid: https://www.coverva.org/en/famis-select HIPP: https://www.coverva.org/en/hipp	1-800-432-5924
WEST VIRGINIA	Medicaid: https://dhhr.wv.gov/bms/ CHIP: http://mywvhipp.com/	Medicaid: 1-304-558-1700 CHIP: 1-855-MyWVHIPP (855-699-8447)
WISCONSIN	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002



To see if any other states have added a premium assistance program since July 31, 2022, 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 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.



Benefits Open Enrollment

Begins Wednesday, October 26 and ends at
11:59 pm ET Wednesday, November 9.

Your elections will go into effect January 1, 2023.

