

The Hershey Company Medical & Prescription Drug

Summary Plan Description (SPD)

Full-Time U.S. Active and Pre-65 Retired Employees
(Except Puerto Rico)

As of January 1, 2020



**SUMMARY OF MATERIAL MODIFICATION
TO THE
HERSHEY COMPANY HEALTH AND WELFARE PLAN
FOR ACTIVE AND INACTIVE EMPLOYEES
AND THE
HERSHEY COMPANY RETIREE MEDICAL AND LIFE INSURANCE PLAN (PRE-65
RETIREES)**

April 2021

Dear Hershey Employee or Pre-65 Retiree:

The Hershey Company Health and Welfare Plan for Active and Inactive Employees and the Hershey Company Retiree Medical and Life Insurance Plan (together, the “Plans”) have been amended as described below, effective January 5, 2021.

This Summary of Material Modifications (“SMM”) provides an overview of the changes and how they may affect you. This SMM supplements the Plans’ Summary Plan Description (“SPD”) previously provided to you. Please read this SMM carefully and keep this SMM with your copy of the Plans’ SPD. Please note, in the event of a conflict between the terms of the applicable Plan document (as amended) and this SMM and/or the Plans’ SPD, the Plan document will control.

Coverage of COVID-19 Preventive Services (Including Vaccines)

During the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19 (the “Public Health Emergency”), the Plans will cover any “qualifying coronavirus preventive service” (within the meaning of 29 CFR § 2590.715–2713) with no cost-sharing, whether the services are provided In-Network or Out-of-Network.

As of the date of this SMM, “qualifying coronavirus preventive service” include three different COVID-19 vaccines (Pfizer-BioNTech, Moderna, and Janssen). Thus, the Plans will cover these COVID-19 vaccines with no cost-sharing, whether the services are provided In-Network or Out-of-Network. The Plans will also cover, without cost-sharing, the administration of the COVID-19 vaccines that are “qualifying coronavirus preventive services.”

After the Public Health Emergency ends, the Plans will cover any COVID-19 services (including COVID-19 vaccines) that are required to be covered by law, with no cost-sharing, when the services are provided In-Network.

* * *

If you have questions about the changes to the Plans, please contact the HR Support Center at askhr@hersheys.com, 800-878-0440 or 717-534-8170.



Table of Contents

Introduction	1
Important Terms	1
Who is Eligible?	7
Eligible Employee.....	7
Eligible Retiree	7
Eligible Long-Term Disability Participant	7
Eligible Dependents	7
Surviving Dependents of Retired Employees	8
Surviving Dependents of Hershey/Hershey Couples Retirees.....	8
Penalty for Ineligible Dependents.....	8
Definition of Spouse	8
Definition of Domestic Partner	9
Who is Not Eligible?	10
Special Rules for “Hershey” Dual Coverage	10
How to Enroll	10
New Hires	10
Newly Eligible Retirees	11
Open Enrollment.....	11
Mid-Year Enrollment: Special Enrollment Rights	11
Mid-Year Enrollment: Qualified Medical Child Support Orders	12
Coverage Levels	12
Who Pays for Your Benefits	12
Pre-Tax Payroll Deductions	12
When Coverage Begins	13
Changing Coverage	13
How to Change Your Coverage	14
When Coverage Ends	14
Rescission in Event of Fraud	15
Continuing Medical Coverage While Receiving Long-Term Disability Benefits	15
Protecting Your Privacy	15
The Hershey Company Notice of Privacy Practices.....	15
Purpose.....	15

Uses and Disclosures Permitted Without Your Authorization or Consent.....	16
Your Rights.....	18
Complaints.....	19
Plan Contact Information.....	20
Continuation of Health Care Coverage – COBRA.....	20
When You May Elect COBRA Coverage.....	21
Applying for COBRA Coverage.....	21
When COBRA Coverage Ends.....	22
Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).....	22
Contact Information.....	22
Your Medical Plan Options.....	22
Highmark Blue Shield Customer Care Advocates.....	23
Your Highmark Blue Shield ID Card.....	23
Medical Benefits Summary.....	24
Deductible.....	27
Deductible – HSA.....	28
Coinsurance.....	28
Out-of-Pocket Maximum.....	29
Health Savings Account (HSA) (available only with the HSA).....	29
HSAs Offer Triple Tax Advantage.....	29
HSA Eligibility.....	30
HSA Contributions.....	30
Rollover from IRA to HSA.....	32
Timing and Amount of HSA Contributions.....	32
If You Enroll Mid-Year.....	32
Your HSA Bank Account.....	32
Using Your HSA Account.....	33
Eligible HSA Expenses.....	34
Ineligible HSA Expenses.....	34
If You Have HSA Money Left Over.....	34
Health Reimbursement Account (HRA).....	34
The Blue Cross and Blue Shield Network.....	36
In-Network versus Out-of-Network Providers.....	36
Finding an In-Network Provider.....	36
Specialists.....	36
Care Away from Home.....	37

Out-of-Area Coverage for Eligible Dependents	37
Wellbeing Program and Resources	37
Tobacco Cessation	38
Critical Care Management	38
Blues on Call (BOC).....	38
Cost Savings Tools	38
Access to the Wellbeing Website	39
What the Medical Plan Options Cover	39
Preventive Care	39
Inpatient Hospital Services	39
Hospital Room and Board.....	39
Inpatient Surgery (see “Surgical Services”)	39
Continued Stay Review.....	41
Case Management.....	41
Outpatient Hospital Services.....	42
Emergency Care.....	42
Outpatient Surgery (see Surgical Services, next)	42
Surgical Services.....	42
Surgery for Treatment of Disease or Injury	42
Reconstructive Surgery	42
Special Surgery	42
Assistant Surgeon.....	43
Second Surgical Opinion	43
Other Services.....	43
Applied Behavioral Benefits for Autism	43
Allergy Treatment.....	44
Ambulance	44
Assisted Fertilization	44
Clinical Trials.....	45
Diabetes Treatment	45
Diagnostic X-ray and Lab.....	45
Durable Medical Equipment	45
End Stage Renal Disease	46
Enteral Formulae.....	46
Home Health Care and Hospice Care	46
The following hospice care services are also covered:.....	46
Home health and hospice benefits will not be paid for:.....	47
Infertility Counseling, Testing and Treatment.....	47
Maternity Care	47
Mental Health Care Services	48
Nicotine Cessation	48
Obesity Treatment.....	48
Office Visits.....	48
Orthotic Devices	48
Prosthetic Appliances.....	48

Skilled Nursing Facility (Nursing Home).....	49
Benefits will not be paid for:	49
Spinal Manipulations (Chiropractic).....	49
Substance Abuse Treatment.....	49
Therapy Services.....	50
Transplant Services	50
Travel & Lodging for Certain Services	50
What the Medical Plan Options Do Not Cover	51
Prescription Drugs	54
The medical plan options pay:	55
In-Network Coverage	55
HRA1	55
HSA	55
HRA2	55
Generic versus Brand Name Drugs.....	56
How Much Could You Save?	56
Mail Order Program	57
Specialty Pharmacy Copay Assistance Program	58
Express Scripts Rx Clinical Management.....	59
Step Therapy	59
Prior Authorization	59
Drugs and Other Items that are not Covered	60
Filing Medical Claims.....	62
Timely Filing Requirements	62
Your Explanation of Benefits (EOB) Statement	63
Administrative Information.....	63
General Plan Information.....	63
Plan Sponsor Information	64
Plan Administrator Information.....	64
Service of Legal Process.....	64
Plan Documents	64
Plan Administration.....	65
Claims Administration	65
Other Legal Information.....	66
Applicable Law	66
Assignment of Benefits.....	66
Coordination of Benefits (COB)	66
How COB Works.....	66
Coordination of Benefits for Children/Qualified Medical Child Support Order	68

Coordination with Auto Insurance.....	68
To Prevent Duplicate Payments – Subrogation and Reimbursement	69
Overpayments or Mistaken Payments	69
Claims Processing and Questions.....	70
Claims Denials and Appeals.....	70
Claims Process	70
Urgent Claims	70
Pre-Service Claims.....	71
Post-Service Claims.....	71
Concurrent Care Claims.....	72
Appeals Process	73
First Level Appeal.....	73
Second Level Appeal	74
External Review.....	75
Preliminary Review	76
Referral to an Independent Review Organization (IRO)	76
Expedited External Review.....	77
Statement of ERISA Rights.....	79
Receive Information about Your Plan and Benefits	79
Continue Group Health Plan Coverage.....	79
Prudent Actions by Plan Fiduciaries	80
Enforce Your Rights	80
Assistance with Your Questions	80
A Word about HSAs	80
Reservation of Rights.....	81
Important Notice.....	81
Appendix A.....	82

Introduction

The Company cares about the health and the wellbeing of all employees and their families. That's why the medical and prescription drug program offers quality coverage at reasonable costs through three different medical plan options. You may choose the option that works best for you and your family.

This Summary Plan Description (SPD) describes the medical and prescription drug program offered through The Hershey Company Health and Welfare Plan for Active and Inactive Employees ("Active Plan") and The Hershey Company Retiree Medical and Life Insurance Plan ("Retiree Plan") (together, the "Plans").

Important Terms

Affiliate	Each other entity which is a member of the controlled group (determined in accordance with Section 414 of the Code) of which the Company is a member.
Authorization	An official agreement by Highmark Blue Shield to pay benefits for specific care, based on consultation between a provider and Highmark's Healthcare Management Services (HMS) division.
Balance Bill	An out-of-network provider's bill for the difference between the Highmark Blue Shield Plan Allowance and the provider's actual charge. You must pay this amount in addition to any deductibles and coinsurance required by the Plans. In-network providers do not balance bill.
Claim	A request for payment for a covered medical service, or for precertification or prior approval of a covered service.
Company	The Hershey Company, a Delaware corporation.
Coinsurance	The percentage you pay for covered services after the deductible is met. Coinsurance does not apply toward your deductible. It does count toward the out-of-pocket maximum.
Deductible	A specified dollar amount you must pay for covered services each year before the Plans begin to pay benefits.
Employer	The Company and any Affiliate that adopts the Plans in accordance with the formal Plan documents, or any successor to the Company or any such Affiliate, and is listed in Appendix A.
Explanation of Benefits (EOB)	A statement from Highmark Blue Shield, showing services performed, total benefits payable by the Plans and the total amount you owe the provider.

Health Savings Account (HSA)

A savings account used in conjunction with a high-deductible health plan that allows users to save money and pay for medical, dental, vision or pharmacy expenses on a tax-free basis. The employee, retiree, and the employer can contribute to the account. Unused money in the account remains with the employee or retiree. The HSA is not subject to the Employee Retirement Income Security Act (ERISA).

Health Reimbursement Account (HRA)

A Health Reimbursement Account is an account-based employer health benefit plan that reimburses employees and retirees for out-of-pocket medical expenses.

The employer sets the rules for the Health Reimbursement Accounts, and unused dollars remain with the employer. Unused dollars do not follow the employee to new employment. An HRA is a notional account; no funds are expensed until reimbursements are paid.

Hershey-Hershey Couple

Two employees employed at the Employer who are spouses.

Host Blue

A Host Blue is an arrangement that applies when members access covered services outside the geographic area that Highmark serves. The Host Blue plan is responsible for contracting and handling all interactions with its participating health care providers.

In-Network Care

Care you receive from in-network doctors, hospitals, rehabilitation centers, labs and other health care providers that have an agreement with Highmark Blue Shield or any other Blue Cross and Blue Shield Health insurance companies and organizations. In-network providers accept the Plan Allowance as payment in full and file claims for you. In-network care is paid at a higher level of benefits than out-of-network care.

Medically Necessary and Appropriate

Service, supplies or medications a provider, using prudent clinical judgment, would use to prevent, evaluate, diagnose or treat an illness, injury or disease or its symptoms and that are:

In accordance with generally accepted medical practices

Appropriate for the symptoms, diagnosis, or treatment of the patient's illness, injury or disease

Provided in the most cost-efficient manner and setting

Not primarily for your or your provider's convenience

Highmark Blue Shield makes the final determination of whether a service is medically necessary and appropriate.

Plan Allowance

The amount used to determine payment by the Plan for covered services provided to you and to determine your liability. The Plan Allowance is based on the type of provider who renders such services or as required by law. The Plan Allowance for an in-area out-of-network provider is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and the Plan's payment. The Plan Allowance for an out-of-area provider is determined based on prices received from local licensees of the Blue Cross Blue Shield Association.

The Plan Allowance for an out-of-area network state-owned psychiatric hospital is what is required by law. In some cases, an allowance may be negotiated with an out-of-area non-participating provider. The negotiated reimbursement amount will be based on prevailing market reimbursement amounts. In the event the negotiations with a non-participating out-of-area provider are unsuccessful, the plan allowance will be based on pricing determined by a national database. For facility claims, the pricing will be determined on the basis of detailed data reflecting actual reported billings and payments over the preceding 24 months and includes an inflation factor. For professional claims, pricing will be determined on median-based cost of care that is adjusted for geography.

When covered services are provided outside of the Plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

In some exception cases, Highmark may pay claims from non-participating health care providers outside of the Plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider inside the Plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

Wellbeing

The Wellbeing Program is designed to help you and your spouse/domestic partner be more involved in your health decisions and make real health improvements. For additional information, please refer to the Wellbeing Program and Resources section.

Out-of-Network Care

Care you receive from health care providers who are not in the Blue Cross and Blue Shield network. You pay more for out-of-network care than in-network care.

Out-of-Pocket Maximum (OOPM)

The amount of money you pay out of your pocket for eligible health care expenses before the program begins to pay 100% for additional eligible expenses. The out-of-pocket maximum includes deductibles and coinsurance. For out-of-network services, it does not include amounts over Highmark Blue Shield’s Plan Allowance.

Plans

The Hershey Company Health and Welfare Plan for Active and Inactive Employees (“Active Plan”) and The Hershey Company Retiree Medical and Life Insurance Plan (“Retiree Plan”)

Precertification

The process through which inpatient admission services are required to be preapproved by Highmark Blue Shield.

Preferred Provider Organization (PPO)

A program that does not require the selection of a primary care physician but is based on a provider network made up of doctors, hospitals and other health care facilities who have an agreement with an insurer or third-party provider. Members may use any provider within the network and receive higher benefits by using in-network providers.

RME (Retiree Medical Eligible) Individual

An employee or former employee who meets the following criteria:
Was born prior to 1954;
Was hired before the dates listed in the table below; and
Attained age forty-five (45) or older as of the dates listed in the table below.

Employees at	Hired Before These Dates
Salaried	1/1/1999
Robinson Hourly	1/1/1999
Memphis Hourly	1/1/1999
Stuarts Draft Hourly	1/1/1999
Y&S Lancaster Hourly	1/1/1999
Reese Plant Hourly	4/30/1999
Hershey and West Hershey Plant Hourly	4/30/1999
Hazleton Hourly	4/30/1999

Or

Is a Switcher Individual who elected RME status.

**SRC
(Supplemental
Retirement
Contribution)
Individual**

An employee or former employee who meets the following criteria:

Meets either one of the following criteria: (i) Was born in 1954 or later; or
(ii) Was hired on or after the dates listed in the table below.

Employees at	Hired On or After These Dates
Salaried	1/1/1999
Robinson Hourly	1/1/1999
Memphis Hourly	1/1/1999
Stuarts Draft Hourly	1/1/1999
Y&S Lancaster Hourly	1/1/1999
Reese Plant Hourly	4/30/1999
Hershey and West Hershey Plant Hourly	4/30/1999
Hazleton Hourly	4/30/1999

And

**SRC
(Supplemental
Retirement
Contribution)
Individual**

Was hired before the dates listed in the table below:

Employees at	Hired Before These Dates
Salaried	6/5/2006
Robinson Hourly	6/5/2006
Memphis Hourly	6/5/2006
Stuarts Draft Hourly	6/5/2006
Y&S Lancaster Hourly	6/5/2006
Reese Plant Hourly	6/5/2006
Hershey and West Hershey Plant Hourly	1/1/2011
Hazleton Hourly	4/1/2012

Or

Is a Switcher Individual who elected SRC status.

Switcher Individual

A union Employee at the Hershey or West Hershey plant or an hourly Employee at the Reese plant, who had reached age 42 ½ (but not 45 or older) and completed 15 or more Years of Service with the Company on April 30, 1999. These employees had the option to elect subsidized Medical Benefits or SRC (Supplemental Retirement Contribution) status under the Plan by December 13, 2002.

And was hired before the dates listed in the table below:

Employees at	Hired Before These Dates
Salaried	6/5/2006
Robinson Hourly	6/5/2006
Memphis Hourly	6/5/2006
Stuarts Draft Hourly	6/5/2006
Y&S Lancaster Hourly	6/5/2006
Reese Plant Hourly	6/5/2006
Hershey and West Hershey Plant Hourly	1/1/2011
Hazleton Hourly	4/1/2012

Summary Plan Description (SPD)

This document, which is required by the Employee Retirement Income Security Act (ERISA), and provides information in simple language about the medical and prescription drug benefits available to full-time U.S. employees and certain retirees under the Plans.

Year of Service

Each twelve (12)-consecutive-calendar-month period beginning on an individual's date of employment or reemployment with the Employer, as the case may be, in which such individual is an employee during each month of such period. Periods of employment which are not separated by a five (5)-consecutive-year break-in-service will be aggregated for the purpose of determining whether an employee or retired employee has satisfied the eligibility requirements set forth below under "Who is Eligible".

Notwithstanding the foregoing, if an employee experiences a break-in-service, credit will be granted for full-time service prior to the break-in-service, provided that the break-in-service does not exceed five (5) consecutive years.

Who is Eligible?

Eligible Employee

You are eligible for the medical and prescription drug program if you are a U.S. active, full-time employee of the Employer (except Puerto Rico), as defined in the Employer's payroll/Human Resources system.

Eligible Retiree

RME Individuals and SRC Individuals who retire from the Employer are eligible for the medical program, as long as they terminate employment with the Employer at or after age fifty-five (55) and after completing five (5) Years of Service (continuous) with the Employer.

Eligible Retirees are only eligible for the medical and prescription drug program described in this SPD until reaching Medicare eligibility due to attainment of age 65, or becoming eligible for Medicare for another reason.

If a retired employee is an Eligible Dependent of an Eligible Employee, the Eligible Retiree will be enrolled in coverage under the medical and prescription drug program as an Eligible Dependent, rather than as a retired employee, unless requested otherwise.

Eligible Long-Term Disability Participant

An employee of the Employer who qualifies for long-term disability (LTD) benefits under the Active Plan, is eligible for the medical and prescription drug program described in this SPD.

Eligible Long-term Disability Participants are only eligible for the medical and prescription drug program described in this SPD until reaching Medicare eligibility due to attainment of age 65, or becoming eligible for Medicare for another reason.

Eligible Dependents

If you are an Eligible Employee, Eligible Retiree, or an Eligible Long-Term Disability Participant, you may also enroll the following dependents for medical and prescription drug benefits:

- Your spouse (as defined below) or qualified domestic partner (as defined below)
- Your dependent children under age 26
- Your disabled, dependent children of any age, if disabled before age 26

Eligible children include biological children, stepchildren, children legally placed for adoption, adopted children of you and/or your spouse or domestic partner and children for whom you are the legal guardian.

A disabled child who is the dependent of an Eligible Employee, Eligible Retiree or Eligible Long-Term Disability Participant is eligible for the medical and prescription drug program described in this SPD.

A spouse of an Eligible Retiree or Eligible Long-Term Disability Participant who is eligible for Medicare due to attainment of age 65, or eligible for Medicare for another reason (e.g., disability), is not eligible for the medical program described in this SPD.

[Surviving Dependents of Retired Employees](#)

Dependents of a deceased retired employee are eligible for the medical program in accordance with Appendix B to The Hershey Company Retiree Medical and Life Insurance Plan, provided the surviving dependent is enrolled in those benefits on the date of the participant's death. In the case of a spouse, such coverage will end when the spouse remarries or gains other coverage. In the case of any dependent, such coverage will end when the dependent becomes eligible for coverage under any other group health plan that provides medical benefits.

You can request information about Retiree Medical and Life Insurance Plans by contacting the HR Support Center at 1-800-878-0440.

[Surviving Dependents of Hershey/Hershey Couples Retirees](#)

Dependents of a deceased Hershey/Hershey Couple retiree are eligible for the medical program in accordance with Appendix B to The Hershey Company Retiree Medical and Life Insurance Plan. The surviving dependent is not required to be enrolled in benefits on the date of the participant's death. The surviving dependent will retain the rate in place at the participant's death. In the case of a spouse, such coverage will end when the spouse remarries or gains other coverage. In the case of any dependent, such coverage will end when the dependent becomes eligible for coverage under any other group health plan that provides medical benefits.

[Penalty for Ineligible Dependents](#)

If you knowingly cover an ineligible dependent, you could be subject to termination of employment and/or required to repay claims that are paid for that ineligible dependent. For example, if you previously covered your spouse and are recently divorced but required to provide benefits coverage due to a court order, you must remove that person from your active coverage. You will need to pay for the coverage through COBRA or another outside plan.

[Definition of Spouse](#)

The Plans define a spouse as an individual who is lawfully married to you and not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

Definition of Domestic Partner

The Plans define same or opposite sex domestic partners as two people who:

- Are living together in a committed exclusive relationship of mutual caring and support for a period of at least one year
- Intend for the domestic partnership to be permanent
- Are financially interdependent in that they are jointly responsible for the common welfare and financial obligations of the household, or the non-employee or retiree is chiefly dependent upon the employee or retiree for care and financial assistance
- Are neither legally married to any other individual, and if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased
- Are mentally competent to enter into a contract according to the laws of the state in which they reside
- Are at least 18 years of age and are old enough to enter into marriage according to the laws of the state in which they reside
- Do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside if they otherwise satisfy all other applicable state marriage requirements

In order to cover a domestic partner under the Plans, you must meet the criteria for qualified domestic partners and provide a signed and notarized Affidavit of Domestic Partnership. Upon request, you must provide proof of financial interdependence and/or proof of common residence. For additional information and forms, please visit the HR Portal at askHR.hersheys.com and search “domestic partner”. Submit questions via the HR Portal at askHR.hersheys.com by clicking on “Request Something” and selecting the Submit Life Event Change Form.

Who is Not Eligible?

The following individuals are not eligible for benefits:

- A part-time, continuous part-time, temporary, or probationary employee;
- A leased employee, even if you are (or may be) reclassified by the courts, the IRS or the Department of Labor as a common-law employee of the Employer;
- An intern;
- A consultant or independent contractor, even if you are (or may be) reclassified by the courts, the IRS or the Department of Labor as a common-law employee of the Employer;
- An individual working in a foreign jurisdiction where United States benefits do not apply (as determined by the Plan Administrator in its sole discretion);
- A nonresident alien; or
- Covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in the Plans

Special Rules for “Hershey” Dual Coverage

If your spouse, parent or domestic partner is an employee of the Employer, special rules apply. Each family member—you, your spouse, parent or domestic partner and your eligible children—may be covered only once. Here’s how it works. One of you can enroll in a medical plan option and cover all eligible dependents and the other can waive coverage. Or, you can both enroll, either in the same plan or different ones, but you cannot cover each other, and you cannot cover the same children in both plans.

How to Enroll

New Hires

If you are eligible, you may enroll in the medical plan on your first day of employment. As a new employee, you will receive a personalized enrollment statement that shows the benefits available to you and the cost, plus instructions on how to enroll. If you do not enroll or waive enrollment within 31 days of your hire date, your enrollment will be defaulted to the HRA2 with Employee Only coverage, at tobacco user rates. You will have to wait until the next Open Enrollment period—generally in the fall—to change your medical plan option or add dependents for the next calendar year. Changes are allowed during the year if you have an event allowing a mid-year change, as described below under the “Mid-Year Enrollment” and “Changing Coverage” sections.

Newly Eligible Retirees

If you are a newly eligible retiree, you will receive a personalized enrollment statement that shows the benefits available to you and the cost, plus instructions on how to enroll. If you do not enroll or waive enrollment within 31 days of the date you are first eligible, you will have to wait until the next Open Enrollment period—generally in the fall—to elect coverage for the next calendar year. Changes are allowed during the year if you have an event allowing a mid-year change, as described below under the “Mid-Year Enrollment” and “Changing Coverage” sections.

Open Enrollment

You may choose or change coverage during Open Enrollment each year. You may also keep the same coverage from year to year. The Plan year runs from January 1 to December 31 each year. Open Enrollment is normally held in the fall. Before the Open Enrollment period, you will receive enrollment information, either online or in hard copy, which shows the available options, cost of coverage and how to enroll.

For details about Open Enrollment, please visit the HR Portal at askHR.hersheys.com and search “open enrollment”. Submit questions via the HR Portal at askHR.hersheys.com by clicking “Request Something” and selecting the General Benefits Inquiry.

Mid-Year Enrollment: Special Enrollment Rights

If you are eligible but not enrolled in medical option under the Plans, you may enroll mid-year if you or an eligible dependent:

- Are covered by Medicaid or Children’s Health Insurance Program (CHIP) coverage and you become ineligible for these programs.
- Become eligible for a premium assistance subsidy under Medicaid or CHIP that may be used for coverage under this Plans.

You have 60 days from the date you lose your coverage or become eligible for the subsidy to enroll in a medical plan option. Please visit the HR Portal at askHR.hersheys.com and search “life event” for the appropriate forms and required documentation. Submit questions via the HR Portal at askHR.hersheys.com by clicking “Request Something” and selecting the General Benefits Inquiry.

In addition, if you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plans if you or your dependents lose eligibility for other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Finally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any eligible dependents within 31 days after the marriage, birth, adoption, or placement for adoption.

Mid-Year Enrollment: Qualified Medical Child Support Orders

You may enroll an eligible dependent child mid-year if required to do so through a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order that requires you to provide health coverage to your children. You may obtain a copy of the Plan's procedures for QMCSO determinations, free of charge, by contacting the Plan Administrator.

Coverage Levels

You may choose one of three coverage levels for health care benefits. The levels are:

- **Employee (or Retiree) Only** – coverage for yourself only
- **Employee (or Retiree) + 1** – for yourself and a spouse, domestic partner or one child
- **Employee (or Retiree) + Family** – coverage for yourself, your spouse or domestic partner and one or more children or for yourself and more than one child

You may cover eligible dependent children until they reach age 26, or if disabled, longer. You will be asked upon enrollment to provide a birth certificate or proof of dependent status if there is not one on file. The Plan will perform random audits of our dependent files and may require additional information.

Who Pays for Your Benefits

You and the Employer share the cost of your benefits. Your share of the cost for each option is shown on the enrollment statement you receive upon enrollment and each fall during Open Enrollment.

If you are an Eligible Retiree or Eligible Long-Term Disability Participant, contact the HR Support Center at 1-800-878-0440 for the rules regarding contributions to medical benefits.

Pre-Tax Payroll Deductions

For Eligible Employees, your contributions for health care benefits are made by payroll deduction on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. This means your contributions are deducted from your pay before taxes are withheld, lowering your taxable salary and your income tax. If your earnings are at or below the Social Security wage base, it will also lower your Social Security tax.

Domestic Partner Tax Considerations

Under current law, if you are not providing over half of their support, domestic partners are not considered eligible dependents for income tax purposes. As a result, your contributions toward your domestic partner's (and his or her eligible dependents) medical, dental and vision coverage will be withheld on a post-tax basis rather than a pre-tax basis. In addition, the COBRA rate less the post-tax contribution you made to cover your domestic partner and his or her eligible dependents is added to your income and subject to ordinary federal, FICA, state, local, and any

other applicable payroll taxes. This amount will be shown on your pay stubs throughout the year and will be reported on your W-2 Form at the end of each calendar year.

When Coverage Begins

If you are an eligible employee, your benefit coverage begins on the day you are hired. For your dependents:

- If enrolled when you are first hired, their coverage begins on your hire date
- If enrolled during Open Enrollment, their coverage begins on the following January 1
- If enrolled as a result of a life event (described next), their coverage begins on the date of the event, provided you enroll them within 31 days of the life event

Changing Coverage

You may change your coverage each year during Open Enrollment. Changes are not allowed during the Plan year (other than the enrollment changes listed above under “Mid-Year Enrollment”) unless you experience a qualifying life event:

- Marriage or declaration of domestic partnership
- Divorce, legal separation or termination of domestic partnership
- Birth, adoption or legal guardianship of a child
- Your death or death of a covered dependent
- Change in employment status for you, your spouse or domestic partner that results in a gain or loss of benefits, including an unpaid leave of absence for you, your spouse or domestic partner
- Change in place of residence or work for you, your spouse or domestic partner that results in one of you living outside the network service area of your medical coverage
- Requirement to cover your dependent according to a judgment, decree or order resulting from your divorce, legal separation or change in legal custody
- Change in a dependent’s eligibility for benefits
- The events listed above as Special Enrollment Events
- Significant change in cost or coverage
- Entitlement to Medicare or Medicaid

You have 31 days from the date of the life event to change your benefits, or you will be unable to make any changes until the next Open Enrollment period – unless you have a subsequent qualifying life event. You may only make changes that are consistent with the life event. For instance, if you marry, you may change your medical plan coverage level (i.e., Employee/Retiree Only or Employee/Retiree + 1), and you may also change your medical plan (i.e., from HRA1 or HRA2 to HSA).

How to Change Your Coverage

If you have a life event during the year and want to change your benefits, please visit the HR Portal at askHR.hersheys.com and search “life event”. Submit your change or ask questions via the HR Portal at askHR.hersheys.com by clicking “Request Something” and selecting the Submit Life Event Change Form. You must provide proof of the change, such as a copy of your divorce decree or letter from your spouse or domestic partner’s employer regarding benefit eligibility. Failure to provide proper documentation or proof of dependent status could result in loss of coverage for your dependents.

When Coverage Ends

Your benefit coverage will end when:

- Your employment ends with the Employer (except for Eligible Retirees)
- You are no longer eligible for benefits (i.e., due to a change in your job status)
- You fail to make any required contributions or monthly payments
- The Plan ends

A dependent’s health care coverage will end when:

- He or she becomes covered as an employee of an Employer
- He or she is no longer an eligible dependent as defined earlier in this booklet
- Your coverage ends
- The Plan no longer offers coverage for dependents

Under some circumstances, you may continue your health care coverage through COBRA continuation coverage.

Rescission in Event of Fraud

Any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plans and the Plans may rescind coverage as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, will invalidate any payment or claims for services and will be grounds for rescinding coverage.

Continuing Medical Coverage While Receiving Long-Term Disability Benefits

If you are an Eligible Employee who is receiving medical coverage under the Plan and you begin receiving long-term disability benefits under the Plan, you may continue medical coverage by making employee contributions at the current employee rate on a monthly basis on or before the due date (plus a 30-day grace period) specified by the Plan Administrator. If any two (2) monthly payments are not received by the specified due date (plus applicable grace period), your medical coverage will be cancelled. If you return to active status as an Eligible Employee, you will have an opportunity to be reinstated in your medical coverage under the Plan.

If you begin receiving long-term disability benefits under the Plan for a second time (or subsequent to the second time), you may elect to continue medical coverage under the Plan for the duration of your long-term disability benefits. During each period of long-term disability leave, you will be required to make employee contributions at the current employee rate on a monthly basis on or before the due date (plus a 30-day grace period) specified by the Plan Administrator. If any two (2) monthly payments are not received by the specified due date (plus applicable grace period) your medical coverage will be cancelled. If a subsequent grace period is missed (second grace period episode) and payment is not made, your medical benefits will be permanently forfeited while on and receiving long-term disability benefits and will continue to be forfeited into Retiree Medical coverage period (if applicable).

Protecting Your Privacy

The Health Insurance Portability and Accountability Act (“HIPAA”) requires health plans to notify Plan participants about policies and practices to protect the confidentiality of your health information. Hershey issues an Employee Privacy Notice to all covered employees and retirees when they enroll for coverage, and every three years. A copy is available below and via the HR Portal at askHR.hersheys.com and search “HIPAA” or contacting the [HR Support Center](#) at 1-800-878-0440.

The Hershey Company Notice of Privacy Practices

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. 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 healthcare 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 healthcare operations. Information about treatment involves the care and services you receive from a healthcare 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 healthcare operations may be used to project future healthcare 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. 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 healthcare 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 your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave SW, Washington, DC, 20201.

Plan Contact Information

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

Plan Sponsor

The Hershey Company
19 East Chocolate Avenue
P.O. Box 810
Hershey, PA 17033-0810
HR Support Center 800-878-0440

Medical Benefit Administrator

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

Pharmacy Benefit Administrator

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

Continuation of Health Care Coverage – COBRA

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The Act provides for continuation of medical, vision and dental coverage for "qualified beneficiaries" (i.e., employees, retirees, and covered dependents who lose their group coverage for a variety of reasons known as "qualified events"). It requires employers to offer the same medical, vision and dental coverage the employee, retiree and dependents had the day before the event that causes them to lose coverage. It also lets employees and retirees continue their Health Care Flexible Spending Account (FSA) through the end of the year. The COBRA coverage described in this booklet is available to you, your covered spouse, domestic partner and eligible dependent children.

If you and any eligible dependents who are covered at the time your coverage under the medical plan option ends elect to continue coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% administrative fee.

Please note: Employer contributions are not made to your HSA account during the period of COBRA coverage under the HSA plan.

When You May Elect COBRA Coverage

You may continue coverage for yourself and your eligible covered dependents for up to 18 months, if your group coverage ends for one of the following reasons:

- You separate from service with the Employer (for reasons other than gross misconduct on your part)
- Your hours are reduced so that you are no longer eligible for the Plan

If you or any of your dependents are determined to be disabled (for Social Security benefit purposes) when the group coverage ends or within the first 60 days of COBRA coverage, coverage for your entire family may continue for a total of 29 months.

Your spouse and covered children may elect to continue coverage for up to 36 months if their coverage ends for one of the following reasons:

- Your death
- Your divorce or legal separation
- Your eligibility for Medicare

Your dependent children may also elect to continue coverage for up to 36 months when they no longer qualify as your dependents.

Applying for COBRA Coverage

When your coverage under a health plan option ends, you or your dependents have 60 days to elect continued coverage. The 60 days is counted from the day your active benefits end or the date the notice is mailed, whichever is later. If you lose coverage due to separation from service or a reduction in work hours, you will automatically receive a notice of your COBRA rights from WageWorks, the Plans' COBRA administrator.

In the case of a divorce, legal separation or when a child no longer qualifies for dependent coverage, you, your spouse or dependent child must notify Hershey and submit your change via the HR Portal at askHR.hersheys.com by clicking "Request Something" and selecting the Submit Life Event Change Form within 60 days from the latest of the qualifying event date or the benefits termination date. WageWorks will then provide information on your COBRA rights.

According to Department of Labor regulations, participants lose their COBRA option if the above qualifying events are not reported within 60 days. If this happens to you, you will receive a notice of unavailability from the Plans or from WageWorks.

When COBRA Coverage Ends

The Plans have the right to end your COBRA coverage if:

- The Company stops providing coverage for all employees
- You do not pay your premiums on time
- You become covered by another group health plan
- You become covered by Medicare
- You extended COBRA coverage to 29 months due to disability, but are no longer considered disabled

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you take military leave, but your coverage under the Plan is terminated, when you return to work at the Employer you will be treated as if you had been actively employed during your leave. A model USERRA notice can be found at:

<https://www.dol.gov/vets/programs/userra/poster.htm>.

Contact Information

The Company's HR Portal and the HR Support Center is a central source of information and reviews issues related to benefits, human resources and company policies. To access the HR Portal or reach the HR Support Center:

- Visit the HR Portal website at askHR.hersheys.com
- Submit questions via the HR Portal by clicking on "Request Something" and selecting the General Benefits Inquiry
- Contact the **HR Support Center** at 1-800-878-0440 which is open Monday through Friday from 8:30 a.m. – 5 p.m. ET and closed on weekends and Hershey holidays

If English is not your primary language, the **HR Support Center** can arrange for you to talk with someone about your benefits in a language that you will understand. Just call the **HR Support Center** and ask to speak with a representative. He or she will connect you with someone who can speak the language of your choice.

Your Medical Plan Options

The medical plan consists of three different Preferred Provider Organization (PPO) options with national Blue Cross and Blue Shield networks. You choose doctors in the network to receive the highest benefits. Referrals are not needed. Benefits are also paid if you choose a doctor outside

the network, but your cost is higher. To help you and your family to maintain good health, all options pay 100% for preventive care with no coinsurance or deductible within the PPO network. Refer to the Medical Benefits Summary chart on the following pages for the benefits payable under each option.

Highmark Blue Shield Customer Care Advocates

The medical plan options are all administered by Highmark Blue Shield, who handles all the claims and administration, even if you use doctors in another Blue Cross or Blue Shield network. Call the Hershey-dedicated Member Services line to speak with a Customer Care Advocate, toll-free, at 866-763-9474 or visit www.highmarkblueshield.com for:

- What is covered
- How much the Plans will pay for a particular service
- Network providers
- Claims questions
- Navigation through the health care system

Be sure you have your member ID number handy when you call. It is printed on your Highmark Blue Shield ID card.

Your Highmark Blue Shield ID Card

When you enroll for a medical plan option, you and each covered dependent will receive an ID card. Your “BlueCard” is recognized throughout the country and is accepted by all Blue Cross and Blue Shield PPO network providers. Carry it with you at all times and show it when you go to the doctor, lab or hospital.

- Your ID card shows: The Highmark Blue Shield logo and “PPO in a Suitcase” symbol, recognized everywhere
- Your name and member ID number
- The Company’s group number
- Coinsurance (\$0 for preventive care under all plan options) and deductible
- Member services toll-free number (866-763-9474)
- Precertification toll free number for inpatient admissions
- Address for member-submitted claims

As a BlueCard member, you are also covered by Global Core, which gives you access to a worldwide network of health care providers and medical assistance services. Call 800-810-2583 for more information about Global Care.

Medical Benefits Summary

The following chart compares in-network and out-of-network benefits under each medical plan option. If you receive care in-network, you will not be billed for charges over Highmark Blue Shield's Plan Allowance. A complete description of covered services is found later in this booklet.

Plan Features	HRA1		HSA		HRA2	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible	\$1,500 / person \$3,000 / family	\$2,250 / person \$4,500 / family	Combined medical/Rx deductible \$1,750 for employee/retiree only \$3,500 for family	Combined medical/Rx deductible \$3,500 for employee/retiree only \$7,000 for family	\$1,750 / person \$3,500 / family	\$3,500 / person \$5,850 / family
Annual out-of-pocket maximum (includes deductible)	\$2,200 / person \$4,400 / family	\$4,400 / person \$8,800 / family	Combined medical/Rx OOP \$2,500 for employee/retiree only \$5,000 for family	Combined medical/Rx OOP \$5,000 for employee/retiree only \$10,000 for family	\$3,000 / person \$6,000 / family	\$6,000 / person \$12,000 / family
Lifetime maximum benefit	Unlimited		Unlimited		Unlimited	
Health Savings Account (HSA) or Health Reimbursement Account (HRA)	HRA Employer contributes: \$500/year for Employee/Retiree Only, \$1,000/year for Employee/Retiree +1, \$1500/year for Family		HSA Employer contributes (on a pro-rated basis, based on date of enrollment) \$750/year for Employee/Retiree Only, \$1,500/year for Employee/Retiree +1, \$2,000/year for Family		HRA Employer contributes: \$300/year for Employee/Retiree Only, \$600/year for Employee/Retiree +1, \$900/year for Family	
Preventive Care – No deductible. See the <i>Highmark Preventive Schedule</i> for details. Plan pays:						
Annual physical and routine GYN	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Well child care & standard immunizations	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Mammogram & pap smear	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Blood pressure screening	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%

	HRA1		HSA		HRA2	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prostate cancer screening	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Colorectal cancer screening (age 50+)	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Other doctor-recommended screenings per preventive schedule	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Flu Shots	100%	Company: 70% Employee/Retiree: 30%	100%	Company: 60% Employee/Retiree 40%	100%	Company: 50% Employee/Retiree: 50%
Physician/Specialist Visits: After Deductible is Met						
Office visits other than preventive	Company: 90% Employee/ Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/ Retiree: 20%	Company: 60% Employee/Retiree 40%	Company: 70% Employee/Retiree 30%	Company: 50% Employee: 50%
Inpatient Hospital Services: After Deductible is Met						
Semi-private hospital room and board, general nursing care, operating room, inpatient lab and x-ray, drugs and medications	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/Retiree 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree30%	Company: 50% Employee/Retiree: 50%
Inpatient surgery and anesthesia	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/ Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree 30%	Company: 50% Employee/Retiree: 50%
Newborn care	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/ Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree 30%	Company: 50% Employee/Retiree: 50%
Mental Health Services: After Deductible is Met						
Mental health/Substance abuse (Inpatient)	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/ Retiree: 20%	Company: 60% Employee/Retiree : 40%	Company: 70% Employee/Retiree : 30%	Company: 50% Employee/Retiree: 50%
Mental health/Substance abuse (Outpatient Office Visit)	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/ Retiree: 20%	Company: 60% Employee/Retiree 40%	Company: 70% Employee/Retiree 30%	Company: 50% Employee/Retiree: 50%

	HRA1		HSA		HRA2	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental health/Substance abuse (Outpatient – All Outpatient Services other than Office Visit)	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree: 30%	Company: 50% Employee/Retiree: 50%
Outpatient Hospital Services: After Deductible is Met						
Pre-admission testing	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree: 30%	Company: 50% Employee/Retiree: 50%
Outpatient Surgery	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree: 30%	Company: 50% Employee/Retiree: 50%
Chemotherapy and radiation treatment	Company: 90% Employee/Retiree: 10%	Company: 70% Employee/Retiree: 30%	Company: 80% Employee/Retiree: 20%	Company: 60% Employee/Retiree: 40%	Company: 70% Employee/Retiree: 30%	Company: 50% Employee/Retiree: 50%
Emergency Care: After Deductible is Met						
Emergency care (hospital emergency room)	Company: 90% Employee/Retiree: 10%	Company: 90% Employee/Retiree: 10%	Company: 80% Employee/Retiree: 20%	Company: 80% Employee/Retiree: 20%	Company: 70% Employee/Retiree: 30%	Company: 70% Employee/Retiree: 30%
Urgent Care	Company: 90% Employee/Retiree: 10%	Company: 90% Employee/Retiree: 10%	Company: 80% Employee/Retiree: 20%	Company: 80% Employee/Retiree: 20%	Company: 70% Employee/Retiree: 30%	Company: 70% Employee/Retiree: 30%

Deductible

A **deductible** is the amount you must pay out of your pocket for certain medical services each Plan year before the Plans begin to pay benefits. Deductible amounts vary by medical plan option, as shown in the Medical Benefits Summary chart. Amounts you pay toward the in-network deductible also count toward the out-of-network deductible, and vice versa.

- The **individual deductible** is what one person must pay before benefits are paid for that person
- The **family deductible** is the total amount that must be paid by a covered family before the Plans begin paying benefits for all family members. It is met when any combination of covered expenses reaches the family deductible amount, even if each covered family member has not met the individual deductible amount. However, no one family member can account for deductible expenses over the individual deductible limit.

Family Deductible Example

For a family in the HRA1, the in-network individual deductible is \$1,500 and the family deductible is \$3,000.

Here are examples of how the family deductible may be met.

If two people are covered	\$1,500 <u>\$1,500</u> \$3,000	The \$3,000 family deductible can only be met as illustrated, since there are just two covered people.
If three or more people are covered	\$1,500 \$750 <u>\$750</u> \$3,000	With three or more people, any combination of eligible expenses can meet the deductible. It is not necessary for all family members to contribute toward the deductible.
If four or more people are covered	\$500 \$500 \$500 <u>\$1,500</u> \$3,000	However, no one person can account for deductible expenses above the individual limit. Please note that this is NOT true of the HSA option.

Family Deductible Example

For a family in the HSA, the in-network family deductible is \$3,500.

Here are examples of how the family deductible may be met.

If two people are covered	\$3,500	The \$3,500 family deductible can be met by any combination of covered family members
	<u>\$0.00</u>	
	\$3,500	
If three or more people are covered	\$500	
	\$500	
	<u>\$2,500</u>	
	\$3,500	
If four or more people are covered	\$200	
	\$200	
	\$100	
	<u>\$3,000</u>	
	\$3,500	

Deductible – HSA

The deductible “rules” for the HSA are different than they are for the HRA options. Please read this section carefully if you are enrolled or planning to enroll in the HSA.

The combined deductible applies to all medical services *and* prescription drugs. Therefore, the full deductible must be met before any services are covered at 80% in the HSA option or before pharmacy services are covered at 80% generic and 60% brand. This does not apply to preventive services which are always covered at 100%.

If you choose Employee/Retiree + 1 or Employee/Retiree + Family coverage under the HSA option, you must pay the entire family deductible (\$3,500) before the Plans pay benefits for any covered family member. Unlike the HRA1 and HRA2 options, the family deductible can be met by any combination of covered expenses that exceeds the family deductible limit, even if only one family member accounts for the entire deductible. For example, the in-network family deductible is \$3,500. If only one person in the family has expenses, he or she must pay the entire \$3,500 deductible before the Plans pay benefits.

Coinsurance

Coinsurance is the percentage of the Plan Allowance you pay for certain services after the deductible is met. Each plan option has a different coinsurance percentage, as shown in the Medical Benefits Summary chart. Keep in mind out-of-network doctors can charge more than the Plan Allowance. When that happens, you must pay the “balance” over the Plan Allowance. This is called **balance billing**. If you receive in-network care, you will not be balance billed for covered services.

Out-of-Pocket Maximum

The **out-of-pocket maximum** protects you from high medical costs due to a catastrophic event or significant medical services. Amounts are different for each plan option as shown in the Medical Benefits Summary chart.

If the amount you pay toward deductibles and coinsurance in a Plan year reaches the out-of-pocket maximum, the Plans will pay 100% for covered services for the rest of that Plan year, up to the Plan Allowance for each service.

If you use out-of-network providers, they may charge you more than Highmark's allowable charge for their services. Amounts over the Plan Allowance do not count toward your out-of-pocket maximum.

Health Savings Account (HSA) (available only with the HSA)

A health savings account, or HSA, is a savings account that is owned by you that you may choose to use to pay out-of-pocket medical expenses on a tax-free basis. It is available to people covered by a qualified high-deductible health plan. Since the deductible is higher than traditional plans, your out-of-pocket expenses may be higher. The HSA is a tax-advantaged account that can help cover those costs if you choose to use it. HSAs are offered alongside the HSA option. If you enroll, the Employer will contribute to your account and you can also contribute. The Employer will contribute even if you choose not to contribute. Please be aware the HSA Option is subject to ERISA rights and responsibilities, but the HSA itself is not. HSAs are not offered with the HRA1 or the HRA2 options.

HSAs Offer Triple Tax Advantage

An HSA lowers your tax bill three ways:

- Your contributions are free from federal income tax
- Earnings on your HSA are tax-free (when used for qualified medical expenses)
- Withdrawals for qualified medical expenses are also free from federal income tax

HSA Eligibility

You must be covered by a high deductible health plan (HDHP) such as the HSA option in order to establish and use an HSA. You are not eligible for the HSA option or HSA account if:

- You can be claimed as a tax dependent of another individual
- You are enrolled in Medicare
- You are enrolled in Medicaid
- You receive benefits under TRICARE
- You have medical coverage other than a high deductible health plan, including secondary coverage under your spouse's plan option or military coverage

Please be aware that if you enroll in the HSA, you may not contribute to a Health Care Flexible Spending Account (FSA).

HSA Contributions

If you enroll in these Plans, the Employer makes regular contributions to your HSA account throughout the year, and you may also contribute through pre-tax payroll deductions (unless you are an Eligible Retiree). For your convenience, accounts are set up automatically for new participants in the HSA option. The account must be set up before the Company can make any contributions to your account. To open the HSA, participants must verify their identity, if necessary, as required by Section 326 of the USA PATRIOT Act. All HSA contributions up to the combined annual limit, shown in the table below, are tax-free. You may use money in your account to pay your deductible and other out-of-pocket health care expenses. Unlike flexible spending accounts (FSA), there is no "use-it-or-lose-it" rule with an HSA; leftover money stays in your account. Annual limits (shown below for 2020) are adjusted yearly, according to the IRS.

If a participant does not verify his/her identity within six (6) months after the participant enrolls in the HSA Medical Plan:

Step 1:

- The participant will forfeit all quarterly company contributions to the participant’s HSA for the time period during which the HSA was not opened

Step 2:

- The Employer will refund all employee contributions through a payroll transaction
- Participant will be taxed on the refunded amount

Step 3:

- The Employer will stop all future pre-tax employee HSA deductions unless and until the participant opens the HSA and re-elects to contribute to the HSA. Note: medical coverage under the HSA plan is still active; however, your election for the health savings account (HSA) have been stopped for all future pre-tax deductions.

2020 Health Savings Account (HSA) Contributions			
Coverage level	Employer Contributes	You May Contribute	Combined Annual IRS Limit
Employee (or Retiree) Only	\$750 (plus \$200 from Company if you get preventive care exam)*	\$2,600	\$3,550
Employee (or Retiree) + 1	\$1,500 (plus \$400 from Company if you and spouse/domestic partner get preventive care exams)*	\$5,200	\$7,100
Employee (or Retiree) + Family	\$2,000 (plus \$400 from Company if you and spouse/domestic partner get preventive care exams)*	\$4,700	\$7,100

* If you are a full-time employee and you and your spouse/domestic partner are covered under the HSA option and either or both of you have an annual preventive care exam from a licensed medical practitioner, the Company will contribute an additional \$200 each (\$200 for you and \$200 for your spouse/domestic partner, as applicable) to your HSA, as shown in the chart above in the “Employer Contributes” column.

Catch-up Contributions

If you are age 55 or older, you can contribute an additional amount of \$1,000 to your HSA. If your spouse is also age 55 or older, your spouse can set up a separate HSA and make his or her own catch-up contribution.

Rollover from IRA to HSA

The IRS allows a one-time tax-free rollover from an IRA to an HSA. Your rollover amount cannot be more than the IRS annual contribution limit when combined with the Employer's and your HSA contributions. Limits are shown in the above chart.

Timing and Amount of HSA Contributions

Your HSA account will be set up automatically by Highmark if you enroll in the HSA option. If you elect to contribute to an HSA, your contributions will be deducted in equal amounts from each paycheck. The Employer will make contributions to your account on a quarterly basis in January, April, July and October. For example, if the annual Employer contribution is \$2,000, $\frac{1}{4}$ or \$500 will be deposited in early January.

If You Enroll Mid-Year

If you join the HSA option after January 1, the Employer will contribute $\frac{1}{4}$ of the annual Employer contribution for each full quarter you participate. You may contribute the difference between the Employer's contribution and the annual IRS maximum. For example, if you are hired on March 2, 2020, and enroll in HSA with Employee/Retiree Only coverage, the Employer will contribute a total of \$562.50 ($\frac{3}{4}$ of the \$750) over the next three quarters for 2020 (\$187.50 each quarter). You may contribute either:

- \$2,100, which is the difference between the prorated IRS maximum of \$2,662.50 ($\frac{9}{12}$ th of the annual limit) and the Employer's contribution; or
- \$2,987.50, which is the difference between the IRS annual maximum of \$3,550 and the Employer's contribution (this requires that you be enrolled in the HSA option on December 1st and enroll in the HSA option for 2021).

Your HSA Bank Account

Your Health Savings Account (HSA) is an FDIC-insured interest-bearing account with PNC Bank, through a partnership with Highmark. It works like a checking account without the checks. Things you should know:

- You are automatically enrolled in an HSA when you enroll in the HSA medical plan
- Your debit card should arrive shortly after enrollment. Additional debit cards are available at no charge upon request
- Once you have more than \$500 in your account, you may move some of the money into a variety of mutual funds managed by PNC Bank

When you enroll in the HSA option, you will receive a Welcome Kit from Highmark with important information about using your HSA account. You will also receive an ID card in the mail, in addition to the HSA debit card. You will need to activate your card before use. Expenses incurred after your coverage begins, but before your account has been opened, are **not** eligible

for reimbursement from your HSA. Your account will be opened automatically upon enrollment in the HSA option. Additional information may be required to activate your account. The Employer contributions will not be deposited unless an account is open and valid for receipt of contributions. Contributions may be returned if an account is not valid within six (6) months after the participant enrolls in the HSA Medical Plan. Employer contributions may be forfeited.

Using Your HSA Account

To access your HSA, view your account balance and enter claims for reimbursement, go to:

- <http://www.highmarkblueshield.com>
- Log in using your Login ID and Password. If this is the first time you log on to the Highmark website, click on Register.
- Under the “Claims and Spending” tab, click on Access Spending Account.

If you have questions about HSA contributions or withdrawal options, please visit the HR Portal at askHR.hersheys.com and search “HSA”. Submit questions via the HR Portal at askHR.hersheys.com by clicking “Request Something” and selecting the General Benefits Inquiry.

- For questions about your account, call Highmark at 866-763-9474

You may use your HSA to reimburse yourself for medical expenses on a tax-free basis. Or, you may pay the costs with out-of-pocket funds and let your HSA account grow. If you want to use your HSA for medical expenses, you may do any of the following:

- Elect to have all claims automatically submitted to your account for reimbursement.
- Use your HSA debit card. You may use it when receiving services or when paying a bill by mail, just as you would use a credit card number. Either way, there must be enough money in your account to cover the expense.
- Request payment be made to your provider.
- Reimburse yourself if you’ve paid medical or other valid health expenses with your own funds.

Distributions from your HSA are tax-free if used to pay eligible medical, prescription drug, dental or vision expenses for yourself or a covered family member. Distributions that are not eligible medical, prescription drug, dental or vision expenses are subject to income tax and may also be subject to a 20% excise tax. You may be reimbursed up to the amount in your account at the time you file your claim. Any balance will be reimbursed as additional contributions are made to your HSA. You can manage your account online at www.highmarkblueshield.com.

Eligible HSA Expenses

Eligible expenses include charges for services covered by the HSA option, 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), other than medical insurance premiums.

Remember, in-network preventive care is covered at 100% and is not subject to the deductible, so HSA withdrawals are not needed. Keep in mind if you use all the money in your HSA before meeting the deductible, you must pay the full cost of additional health care services until the deductible is met. You can minimize your out-of-pocket costs by taking advantage of the discounts offered by in-network providers.

As a result of The Patient Protection and Affordable Care Act (PPACA), HSA holders must have a prescription for any over-the-counter medicine and drugs (other than insulin) in order to be reimbursed on a tax-free basis. Additionally, you must first pay for the over-the-counter medicine and drugs and then submit for reimbursement with a copy of the prescription. You may still be reimbursed for insulin and certain over-the-counter items other than medicine or drugs, such as bandages and first-aid kits, without a prescription.

Ineligible HSA Expenses

Since the definition of a tax dependent is different under the Internal Revenue Code's HSA rules than under The Patient Protection and Affordable Care Act (dependents to age 26 without regard to financial or tax status), be aware that medical expenses incurred by your adult child will not be a qualified expense under the HSA unless your adult child is your tax dependent. HSA dollars used for non-tax dependent adult children must be reported as income and may be subject to a 20% penalty. Talk to your tax advisor for more details.

If You Have HSA Money Left Over

If you have money left in your HSA at the end of the Plan year, it carries over to the following year tax-free, with earnings. You may use it for future health care expenses, including medical expenses in retirement, long-term care or COBRA premiums. If you withdraw the money for anything other than eligible health care expenses, you must pay income tax and a 20% penalty unless the withdrawal occurs when you die, become disabled or turn 65. Your HSA is portable, which means you take it with you if you leave the company.

Health Reimbursement Account (HRA)

The HRA is an employer-sponsored, tax-advantaged health benefit plan that provides upfront money that will be applied to medical out-of-pocket costs. Employees and Retirees cannot contribute to the HRA – only the Employer may allocate tax-free funds to your account. If you do not use all the funds in one plan year, the balance will roll over to the following plan year if you elect to continue to enroll in the HRA. However, an HRA is not portable, which means you forfeit any unused funds when you change plans or leave the Employer. Your HRA doesn't earn interest and there are no investment options, so your account will only grow with contributions

from the Employer. However, with this type of account, there is no restriction on FSA participation, so – if you are an active employee – you may also contribute to a Health Care FSA.

Your HRA is a book-keeping account and the Company pays HRA benefits from general assets. No money is set aside or contributed to a trust to fund the HRA.

The Employer will allocate the following amounts to your HRA should you enroll in the plan:

Coverage	HRA1	HRA2
Employee (or Retiree) only	\$500*	\$300*
Employee (or Retiree) +1	\$1,000*	\$600*
Family	\$1,500*	\$900*

*If you are a full-time employee and you and your spouse/domestic partner are covered under the HRA1 or HRA2 option and either or both of you have an annual preventive care exam from a licensed medical practitioner, the Company will allocate an additional \$200 each (\$200 for you and \$200 for your spouse/domestic partner, as applicable) to your HRA, in addition to the amount shown in the chart above.

The amount allocated to your account will be available on January 1 of the plan year in the full amount listed above.

The dollars your Employer contributes to the account will be used only to pay medical claims. **These dollars cannot be used to pay for prescription claims.** When you have exhausted the HRA funds you can pay claims with your own funds or, if you are an active employee, use funds from a health care flexible spending account. If HRA dollars are used to pay a claim for medical services, an explanation of benefits (EOB) will indicate the claim was paid with HRA dollars. No debit card will be issued for Health Reimbursement accounts.

There will be a 3-month runout at the end of each plan year where funds from the prior year can be used to pay claims if still available.

If an employee or retiree joins the plan after the start of the plan year they will receive 1/12 of the HRA funds described above for each month of the plan year they are eligible. For example, if an employee or retiree joins the plan on March 1st, they will receive 10/12 of the funds they are eligible for based on their coverage tier.

Employees and Retirees will be able to rollover funds in the plan from year to year. However, rollovers are limited to amounts that do not exceed the annual deductible based upon the tier level you are enrolled in. For example, if you are enrolled in the HRA1 with Employee/Retiree only coverage, you cannot exceed \$1,500 which is the individual annual deductible. For those enrolled in the HRA1 as Employee/Retiree +1 or Family, you cannot roll over funds that would exceed the \$3,000 annual deductible.

The Blue Cross and Blue Shield Network

The Blue Cross and Blue Shield network of doctors, hospitals, and other health care providers have agreed to accept specified fees for their services. All medical plan options give you access to Blue Cross and Blue Shield networks nationwide. You may see any network doctor without a referral. Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists.

In-Network versus Out-of-Network Providers

The Plan pays benefits for both in-network and out-of-network services, but there are in-network advantages:

If you use a Provider...	Then...
In-network	<ul style="list-style-type: none">• You pay less out of your pocket• No “balance billing”• Your claims are filed for you• Highmark Blue Shield pays the provider directly
Out-of-network	<ul style="list-style-type: none">• You pay more out of your pocket• You pay all charges over the Plan Allowance for each service – this is called “balance billing”• In most cases, you must file your own claims• You may need to pay the provider in full and wait for reimbursement from Highmark Blue Shield

Finding an In-Network Provider

Finding in-network doctors, hospitals, and other providers is easy. You may call Highmark Blue Shield at 866-763-9474 or find a provider online:

1. Logon to www.highmarkblueshield.com
2. On the home page, go to *Find Providers*, then click on *Find a Doctor, Hospital or Other Healthcare Professional*
3. Select the provider type from the drop-down menu, enter your address or zip code and plan name “PPO Blue”

Your results will be shown in order of their distance from the zip code or location you entered. You may also sort providers by name, specialty or practice.

Specialists

The medical plan options do not require a referral for specialty care. You may select any doctor you wish. You will pay less if you use an in-network specialist. If your general doctor suggests you see a specialist, it is your responsibility to verify whether the specialist is in network. If you visit a specialist who is not in the network, you will receive out-of-network benefits, even if the doctor who suggested the specialist is in the network.

Care Away from Home

The medical plan options cover you and your dependents when away from home.

- If you have a medical emergency while traveling, seek treatment from the nearest hospital, emergency room or clinic. The claim will be paid at the in-network benefit level, even at hospitals that do not participate in a Blue Cross or Blue Shield network
- For non-emergency care, you may see any Blue Cross and Blue Shield network provider and receive in-network benefits

Out-of-Area Coverage for Eligible Dependents

If you have dependents away at school, they can select Blue Cross and Blue Shield network doctors near them and be covered as if they were at home (in-network). Here's how it works:

- Care provided by the school's medical center is not covered under any of the medical plan options
- For non-emergency care, the student must use Blue Cross and Blue Shield network providers in order to be reimbursed at the higher in-network benefit level. Dependents who receive covered services for non-emergency care from a provider who does not belong to the Blue Cross and Blue Shield network will receive the lower level of benefits because such care is considered out-of-network care.
- Dependents who receive covered services for emergency care from a provider who does not belong to the Blue Cross and Blue Shield network will be reimbursed at the in-network benefit level.

Wellbeing Program and Resources

The Wellbeing Program is designed to help you and your spouse/domestic partner be more involved in health decisions and make real health improvements. Participation in the Wellbeing Program is voluntary. If you are a full-time employee and you and your spouse/domestic partner are covered under any of the medical plan options and either you or both have an annual preventive care exam from a licensed medical practitioner, the Company will allocate \$200 each (\$200 for you and \$200 for your spouse/domestic partner, as applicable) to either your HRA or HSA, depending upon the enrolled medical plan option.

Please note: Puerto Rico employees and U.S. and Puerto Rico employees who are on short-term disability (STD) and workers compensation (WC), U.S. Expats and their spouses/domestic partners are not eligible for these Company HRA and HSA contributions. Also, the Wellbeing Program and incentives are subject to change.

Tobacco Cessation

If you are a current tobacco-user, make sure to take advantage of an authorized cessation program, so you can avoid the tobacco-user surcharge and save money in the future. To change your smoker or tobacco user designation, you must enroll in and complete five (5) sessions in an authorized tobacco cessation program. Contact Highmark or the Quit for Life program for options to help you quit.

Highmark Blue Shield provides a wide range of tools and resources to give you the best healthcare experience possible. These resources include:

- Critical Care Management
- Blues on Call
- Cost Saving Tools

Critical Care Management

A Customer Care Advocate is your single source for all matters relating to your health care coverage. From help arranging a provider appointment to managing a chronic condition, your Advocate can provide you with fast, efficient service to get the answers you need.

Call an Advocate to:

- Ask if a procedure is covered by your plan
- Find out where to go for the most cost-effective care
- Talk about an upcoming surgery
- Establish a diet and exercise plan to meet your needs

To reach a Customer Care Advocate, call 866-763-9474. Representatives are available from 8:00 a.m. to 8:00 p.m. E.T.

Blues on Call (BOC)

Blues on Call is a comprehensive, confidential health information and support service available to 24 hours a day, 7 days a week. To reach a Blues on Call health coach, call 866-763-9474.

Cost Savings Tools

Locate nearby primary care physicians, specialists or health care facilities with the Find a Doctor tool. Estimate out of pocket costs at different providers for up to 1,600 different procedures with the Care Cost Estimator. Save money and time by using the Virtual Medicine benefit for minor medical issues. Access valuable discounts on all kinds of health and wellness products, services

and classes at vendors nationwide with our Blue365 discount program. Go to highmarkblueshield.com for more information.

Access to the Wellbeing Website

Log into the Sharecare website at www.mycare.sharecare.com, click on “Create My Account”, enter the required information and agree to the terms and conditions. You, your spouse and dependents must create separate accounts.

What the Medical Plan Options Cover

All medical plan options pay benefits for the services described below. Services must be medically necessary and appropriate. Some services are subject to deductibles and coinsurance, as shown in the *Medical Benefits Summary* chart found earlier in this booklet. In-network care is paid at a higher level of coverage than out-of-network care.

Preventive Care

Covered preventive care services are those required by regulations issued under the Patient Protection and Affordable Care Act (PPACA) and are covered by these Plans with no Deductible or Coinsurance from you or your covered dependent when provided as In-Network Care. That means the Plans pay 100% of the Plan Allowance.

Highmark Blue Shield’s *Preventive Care Schedule* is reviewed and updated periodically by the plan based on the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association and medical consultants. Accordingly, the frequency and eligibility of services is subject to change. You may call Customer Service using the number on your ID card for additional information about these services (or view the federal government’s websites, <http://www.healthcare.gov/center/regulations/prevention.html>; <http://www.ahrq.gov/clinic/uspstfix.htm>; or <http://www.cdc.gov/vaccines/acip/index.html>).

As of the date this Summary Plan Description (SPD) was prepared, covered services include those listed under, “Preventive Care Benefits for Adults”, “Preventive Care Benefits for Women” and “Preventive Care Benefits for Children” on the <http://www.healthcare.gov/center/regulations/prevention.html> website.

Inpatient Hospital Services

Hospital Room and Board

- Semi-private room and board

Inpatient Surgery (see “Surgical Services”)

- Pre-admission testing
- Surgeon’s fees

- Anesthesia, anesthesia supplies and services
- Facility fees

Hospital Services

- Pre-admission testing
- Operating, delivery and treatment rooms and equipment
- Drugs and medicines
- Whole blood, blood components and blood derivatives not officially classified as drugs (since the Plan participates with a variety of blood banks, you will rarely be charged for use of blood or blood products)
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services
- Therapy services
- Concurrent care (care by a doctor other than your surgeon or care by two or more doctors when your condition requires the skills of separate doctors)
- Consultation by another doctor when requested by the attending physician
- Inpatient medical care visits
- Intensive care
- Routine newborn care (remember to add your new baby to your coverage within 31 days from the date of birth)

Prior Authorization is Required for Hospital Admissions

All hospital admissions (medical, mental health and substance abuse) require prior authorization by Healthcare Management Services (HMS), a division of Highmark Blue Shield.

- When you use an in-network provider, they will most often contact Highmark for prior authorization (precertification), using the number on the back of your ID card. However, you should always confirm this precertification, since you are responsible for this procedure
- For an out-of-network inpatient admission, you must contact Highmark. Call Highmark at 866-763-9474 seven to ten days before your planned admission for authorization and to learn your financial responsibility
- If you do not pre-certify your admission to an out-of-network facility, Highmark will review your care after services are received. If the admission is determined not medically necessary and appropriate, you will be responsible for all costs not covered by the Plans
- For emergency or maternity-related admissions, call Highmark within 48 hours of the admission, or as soon as reasonably possible

Continued Stay Review

Highmark monitors inpatient hospital stays to ensure the length of stay is appropriate. Highmark will consult with your doctor to determine whether an extended stay, beyond the authorized number of days, is medically necessary and appropriate. If it is not, and you remain in the hospital anyway, no further benefits will be provided for the remainder of the stay.

Case Management

For serious injury or illness, case management may be used to:

- Work collaboratively with you and your family to coordinate and implement a plan of care which meets your holistic needs
- Identify community-based support and educational services to assist with your ongoing health care needs
- Help coordinate benefits and alternative resources

Outpatient Hospital Services

Emergency Care

- If you have an emergency, go to the nearest emergency facility or call 911
- Emergency treatment will be covered at in-network levels, even at out-of-network facilities
- If the situation is not an emergency, call 888-258-3428 for medical advice and/or see a network doctor as soon as possible

Outpatient Surgery (see Surgical Services, next)

- Pre-surgical testing
- Surgeon's fees
- Hospital services and supplies including anesthesia
- Facility fees

Surgical Services

Surgery for Treatment of Disease or Injury

- Surgery performed by a licensed provider
- Visits before and after surgery

If two or more procedures are performed during the same surgery by the same surgeon, payment is considered at 100% of the allowable charge for the primary procedure and 50% of the allowable charge for each secondary procedure.

Reconstructive Surgery

- All stages of the reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Breast prostheses
- Treatment of physical complications from mastectomy, including lymphedemas

Special Surgery

- Sterilization and procedures to reverse sterilization
- Circumcision

- Oral surgery to repair accidental injury
- Oral surgery to correct physical abnormalities that cause severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palate

Assistant Surgeon

- Assistant surgeon who actively assists the operating surgeon if patient's condition warrants it and an intern, resident, or house staff member is not available

Second Surgical Opinion

- Applies to elective surgery (surgery that is not an emergency and can be deferred)
- Second opinion consultation with a doctor other than the one who first recommended surgery
- Third opinion if the first two conflict

Other Services

Applied Behavioral Benefits for Autism

- Autism Spectrum Disorders: Any pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified
- Autism Spectrum Disorders: Benefits are provided to members under 21 years of age for the following:
 - Diagnostic Assessment of Autism Spectrum Disorders: Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder
 - Treatment of Autism Spectrum Disorders: Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics

- Treatment may include the following medically necessary and appropriate services:
 - Psychiatric and psychological care: Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry
 - Rehabilitative care: Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of an attained skill or function
 - Therapeutic care: Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

Allergy Treatment

- Allergy testing including percutaneous, intra-cutaneous, and patch tests
- Allergy extract and allergy injections

Ambulance

Ambulance service to the closest facility that can provide the services you need:

- From your home, the scene of an accident or medical emergency to a hospital
- Between hospitals
- Between a hospital and a skilled nursing facility

Assisted Fertilization

Benefits will be provided for covered services to promote fertility through Progyny. If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate by dialing (855) 507-6309. Services include:

- Artificial Insemination (IUI)
- Cryopreservation of oocytes and sperm
- FDA Bloodwork and Testing
- Fresh IVF Cycle
- Frozen Embryo Transfer (FET)
- Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF Freeze-All

- Patient Care Advocate (PCA) Concierge Support
- PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability

Benefits subject to a Smart Cycle lifetime maximum per family, for medical services. Specifically, the Progyny benefit is subject to a 3 Smart Cycle lifetime maximum. Each treatment type including Artificial insemination and IVF has a Smart Value allocation that is deducted from the total number of Smart Cycles available. Prescription drugs are carved out to Express Scripts. Prescription drugs for fertility treatments are administered by Express Scripts and subject to a lifetime limit of \$50,000.

Please see the section “What the Medical Plan Options Do Not Cover” for a list of fertility services that are not covered.

Clinical Trials

- Routine patient costs otherwise covered by the Plans that are associated with participation in Phases I-IV of approved clinical trials (i.e., clinical trials that are federally funded and certain drug trials) to treat cancer or other life-threatening conditions, as determined by Highmark Blue Shield and as required by law. These costs will be subject to the Plans’ otherwise applicable deductibles and limitations and do not include costs of the investigational item, device or service, items that are provided for data collection, or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Diabetes Treatment

- Regular testing and treatment
- Outpatient diabetes self-management education, including medical nutrition therapy, when certified by your doctor
- Diabetes supplies, including blood glucose monitors, monitor supplies and insulin infusion devices

Diagnostic X-ray and Lab

- Diagnostic x-ray including radiology, MRI, ultrasound and nuclear medicine
- Laboratory and pathology tests
- Diagnostic procedures including electrocardiogram (ECG) and electroencephalogram (EEG)

Durable Medical Equipment

- Rental or purchase of special medical supplies and equipment, such as hospital beds, wheelchairs and crutches

End Stage Renal Disease

- For the treatment of end stage renal disease, Highmark will be the primary payer (Medicare secondary) for the 30-month period following Medicare entitlement due to the disease
- The Plans will treat the participant as if he or she is enrolled in Medicare

Enteral Formulae

- Liquid nutrition administered into the gastrointestinal tract orally or through a tube
- Must be administered under doctor's direction
- Only covered for therapeutic treatment of certain metabolic disorders including phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria

Home Health Care and Hospice Care

Services by a home health care or hospice provider. Hospice care services are covered for members with a life expectancy of 180 days or less.

- Skilled nursing services of a Registered Nurse or Licensed Practical Nurse, excluding private duty nursing services
- Physical therapy, occupational therapy and speech therapy
- Medical and surgical supplies provided by the home health care or hospice provider
- Oxygen and its administration
- Home infusion therapy
- Dietitian services
- Medical social service consultations
- Health aide services to a member who is receiving covered nursing or therapy services

The following hospice care services are also covered:

- Respite care (temporary care provided to relieve the primary caregiver for short periods)
- Family counseling related to the member's terminal condition

Home health and hospice benefits will not be paid for:

- Homemaker services
- Maintenance therapy
- Dialysis treatment
- Custodial care
- Food or home delivered meals

Infertility Counseling, Testing and Treatment

- Treatment includes coverage for the treatment of a physical or medical problem associated with infertility. The Hershey Company has partnered with Progyny, a leading fertility benefits solution, to provide an inclusive family building benefit for every unique path to parenthood. To learn more and activate the benefit, contact the dedicated Progyny patient care advocate line at 1-855.507.6309. A member guide is available on the HR portal at askHR.hersheys.com by searching “fertility benefit”.

Maternity Care

- Prenatal visits
- Routine lab tests, screenings and ultrasound
- Hospital room, board and necessary hospital services
- Delivery
- Postpartum and newborn care in the hospital
- Maternity home health care visit

In compliance with the Newborns’ and Mothers’ Health Protection Act, the Plans pay for any hospital stay in connection with childbirth for the mother or newborn child for a length of at least 48 hours following a normal vaginal delivery or at least 96 hours following a cesarean section. Shorter stays are permitted if the doctor and mother agree to an earlier discharge. In the case of shorter hospital stays, the Plans cover one maternity home health care visit within 48 hours of discharge from the hospital. You can have the visit at home or in the doctor’s office. It includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests and maternal and neonatal physical assessments.

Mental Health Care Services

- Inpatient facility
- Inpatient psychotherapy, psychological testing and family counseling
- Mental health residential treatment services for inpatient non-hospital residential and rehabilitation therapy
- Outpatient visits with a certified psychiatrist, psychologist or social worker
- Electroshock or convulsive drug therapy
- For immediate referrals or to pre-certify a mental health hospital admission, call 800-628-0816

Nicotine Cessation

- Nicotine cessation support programs and/or classes. Additional services through the Wellbeing program

Obesity Treatment

- Gastric bypass surgery
- Adjustable gastric band

Office Visits

- For diagnosis or treatment of a medical condition, illness or injury
- Facility fees may be applied

Orthotic Devices

- Purchase, fitting, repairs and replacement of supportive devices, such as braces or boots

Prosthetic Appliances

- Purchase, fitting, repairs and replacements of prosthetic devices, such as artificial limbs
- One wig or hairpiece per person per lifetime if needed after chemotherapy or radiation treatment
- Dental appliances are not covered
- Replacement of cataract lenses is covered only if new cataract eyeglass lenses or contact lenses are needed because of a prescription change. Eyeglass frames are not covered

- Appliances may be replaced once every two years due to irreparable damage and/or normal wear or a significant change in medical condition

Skilled Nursing Facility (Nursing Home)

- Semiprivate room and board
- Drugs and medicines
- Diagnostic services
- Therapy services
- Inpatient medical care visits

Benefits will not be paid for:

- Assistance with activities of daily living
- Custodial care
- Convalescent care for substance abuse or mental illness

Spinal Manipulations (Chiropractic)

- Spinal manipulations to detect and correct structural imbalance or subluxation related to distortion, misalignment, or subluxation of the vertebral column. Subluxation is when one or more of the bones of your spine (vertebrae) move out of position and create pressure on, or irritate spinal nerves
- Maximum 30 treatments per year

Substance Abuse Treatment

- Inpatient detoxification and rehabilitation in a hospital or alcohol or drug abuse treatment facility
- Alcohol or drug abuse treatment facility services for inpatient nonhospital residential and rehabilitation therapy
- Individual and group counseling and psychotherapy, psychological testing and family counseling

For immediate referrals or to pre-certify a substance abuse admission, call 800-628-0816.

Therapy Services

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Respiratory therapy
- Physical therapy (maximum 30 visits per covered person per year)
- Occupational therapy (maximum 30 visits per covered person per year)
- Speech therapy (maximum 30 visits per covered person per year)
- Infusion therapy, including home infusion
- Cardiac rehabilitation

Transplant Services

- Hospital and medical expenses directly related to transplant of organs, bones or tissue
- Your expenses and those of the transplant donor or recipient, to the extent that his or her expenses are not covered by another medical plan

Travel & Lodging for Certain Services

- A \$10,000 lifetime maximum allowance for travel reimbursement for the patient and caregiver (or patient and two parents if the patient is a minor). The patient must be receiving care at least 100 miles from their home to qualify and it only applies to the following services: transplants, spinal surgery, knee/hip replacements, cardiac care, bariatric surgery or gender dysphoria (gender identify disorder).
- Claims must be manually submitted with itemized receipts and are manually reviewed for eligibility. Claims include services such as car rental/transportation, lodging, food and parking but do not include alcohol and entertainment. Note: reimbursements will follow IRS and tax regulations.
- Car rental, hotels, meals and parking must be in accordance with our company travel policy (i.e. standard sized vehicle, etc.)

Is it Covered?

**If you have questions about what is or is not covered by the plan, call
Highmark Blue Shield at 866-763-9474.**

What the Medical Plan Options Do Not Cover

The medical plan options will not pay benefits for:

- Services or supplies that are not medically necessary or appropriate as determined by Highmark Blue Shield.
- Services not prescribed by or performed by or upon the direction of a licensed provider or an eligible provider as defined earlier in this booklet; rendered by other than ancillary provider, facility providers and professional providers
- Services which are submitted by a certified registered nurse and another licensed provider for the same services performed on the same date for the same member
- Provider charges over the Plan Allowance
- Deductibles, coinsurance or penalties you are required to pay under the Plans
- Services which are experimental or investigative in nature
- Services received before you became covered under the Plans or after your coverage ends
- Services for loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation or because of an act of war whether declared or undeclared
- Expenses which you have no legal obligation to pay
- Services received from a medical or dental department maintained by an employer, a mutual benefit association, labor union, trust or similar person or group
- Services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law
- Expenses covered by Medicare when Medicare is primary
- Medicare or Medicare supplement plan deductibles and coinsurance, to the extent that payment has been made under Medicare when Medicare is primary
- Medical expenses covered under Workers' Compensation, no-fault automobile insurance or similar statutory programs

- Medical expenses for service-connected illness or injury that are covered by the armed forces or Veteran's Administration
- Services received from a member of your immediate family
- Services performed as part of an education or training program
- Cosmetic surgery unless necessary to correct a condition resulting from an accident, birth defect, or covered disease or injury
- Telephone consultations with the exception of Teladoc telemedicine service
- Charges for missed appointments or completing claim forms
- Personal hygiene and convenience items such as radio and television rentals, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators or lifts
- Inpatient admissions which are primarily for diagnostic studies or physical medicine services
- Custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care
- Outpatient therapy and rehabilitation services when there is no expectation of additional functional progress, unless medically necessary and appropriate
- Dental services and oral surgery, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face and for orthodontic treatment for congenital cleft palates
- Treatment of temporomandibular joint (jaw hinge) syndrome unless caused by documented organic joint disease or physical trauma
- Foot care, except capsular or bone surgery related to bunions, surgery for ingrown toenails, and orthotics when related to the treatment of diabetes
- Cochlear implants, hearing aids, tinnitus maskers or examinations for prescription or fitting of hearing aids
- Eyeglasses or contact lenses and the exam for their fitting, except when following cataract surgery
- Correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services
- Weight reduction programs, unless medically necessary and appropriate determined by Highmark Blue Shield.

- Treatment of obesity, except for the gastric bypass and adjustable gastric band benefit under the medical plan options, or as otherwise set forth in the predefined preventive schedule
- Food, formula, supplements or other nutritional products except enteral formulae for therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria
- Medical equipment and supplies of an expendable nature, such as incontinence pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings and dressings, except when part of the member's treatment program (i.e., inpatient or outpatient surgery, hospital stays, home health care and certain supplies in limited numbers, such as catheters and ostomy supplies) and determined to be medically appropriate by Highmark Blue Shield
- Immunizations required for foreign travel
- Routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein
- Acupuncture
- Nicotine cessation support programs and/or classes
- Allergy testing, except as provided herein
- Ambulance services, except as provided herein
- For elective abortions, except those abortions necessary to avert the death of the mother or to terminate pregnancies caused by rape or incest
- Private duty nursing
- Skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience
- Services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services, homemaker services, maintenance therapy, dialysis treatment, custodial care, food or home-delivered meals
- Biofeedback therapy
- Blood pressure monitors

- Orthoptics and pleoptics (i.e., muscle and eye exercises for the prevention and correction of vision deformities)
- Treatment of sexual dysfunction that is not related to organic disease or injury, except as covered under the prescription drug benefit
- Any other medical or dental service or treatment except as provided in the Plan contract or as mandated by law
- Any illness or injury suffered during the commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence
- Any care, treatment, prescription drug, or service which has been disallowed under the provisions of the Healthcare Management program
- The following fertility services: home ovulation prediction kits, any fertility services for dependent children, services and supplies furnished by a provider outside of the Progyny network, and treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

Prescription Drugs

All medical plan options include prescription drug benefits through Express Scripts the Pharmacy Benefits Manager (PBM). The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Mail Service pharmacy. The PBM also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may access the covered Prescription Drug list at www.express-scripts.com or on the HR Portal at askHR.hersheys.com and search “Express Scripts”. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plans may, in their sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plans or utilization guidelines.

The medical plan options pay:

- 80% for generic drugs (you pay 20%)
- 60% for brand-name drugs (you pay 40%) if ordered by your doctor or if a generic is not available
- 80% for diabetic supplies and insulin, injectable or oral (you pay 20%)

Under the HRA options, there is no deductible for prescription drugs. With the HSA option, prescriptions are subject to a **combined** medical and prescription deductible and can be reimbursed with money from your HSA account.

Prescription Drug Out-of-Pocket Maximum

The out-of-pocket maximum is the most you have to pay for prescription drugs each year. It varies by plan:

In-Network Coverage	HRA1	HSA	HRA2
Rx Out-of-Pocket Maximums	Separate from medical plan \$1,500 per person \$3,000 per family	Included under medical plan out-of-pocket maximum	Separate from medical plan \$1,500 per person \$3,000 per family
PPACA Preventive Medications For a list go to www.express-scripts.com or call 877-309-6408	100% coverage No Coinsurance	100% coverage No Coinsurance	100% coverage No Coinsurance
Generic	80% Company 20% Employee/Retiree	80% Company 20% Employee/Retiree	80% Company 20% Employee/Retiree
Brand Name	60% Company 40% Employee/Retiree	60% Company 40% Employee/Retiree	60% Company 40% Employee/Retiree
<ul style="list-style-type: none"> • Out-of-network pharmacies and prescription services are not covered • 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 			

Generic versus Brand Name Drugs

A generic drug is a chemical equivalent of a brand-name drug that is no longer protected by a patent. A generic generally serves the same purpose as the original drug. But the generic's price is less since the cost of research, development and marketing was paid by the original manufacturer. Generic equivalents are not available for all brand-name drugs.

You are encouraged to use generic drugs whenever possible. If your doctor states that a brand-name drug is medically necessary, you pay the 40% brand-name coinsurance. But if your doctor does not order brand name and you choose a brand name when a generic is available, you must pay the 40% coinsurance plus the difference between the cost of the generic and the brand-name drug. For example, if a generic drug costs \$30 and its brand name equivalent costs \$50, here is what you would pay:

If You Choose	You Pay	
Generic	20% (coinsurance) x \$30 (generic cost) =	\$6
Brand Name (medically necessary)	40% (coinsurance) x \$50 (brand-name cost) =	\$20
Brand Name (not medically necessary)	40% (coinsurance) x \$50 (brand-name cost) =	\$20
	+ \$50 (brand-name cost) - \$30 (generic cost) =	+ \$20
	Total	\$40
<p>You save \$34 by choosing the generic drug. Generic drug costs \$6 minus Brand Name Cost \$40 = \$34 Savings</p>		

How Much Could You Save?

To find out how much you can save on a specific medication by using the generic equivalent, or to price out any medications, go to www.express-scripts.com. After logging in, click on "My Prescription Plan" and then click on "Price a Drug." Enter the medication name and click on continue to choose the dosage amount.

Mail Order Program

You may have prescriptions filled at a retail pharmacy or through a mail order service. Mail order is for medicine you take on a regular basis, such as blood pressure or diabetes medications. There are several advantages to mail order:

- **Convenience** – You can receive up to a 90-day supply through the mail order program. Retail pharmacies may not give you more than a 30-day supply at one time under this plan
- **Cost** – For most brand-name drugs purchased from the mail order pharmacy, you save an additional 7% - 8% of the total cost compared to retail, plus the pharmacy's dispensing fee per prescription (\$1.50 - \$2.00 depending upon your pharmacy and drug)

Mail order forms are available from:

- **Express Scripts** – visit www.express-scripts.com or call **877-309-6408**
- Once you register as a member at www.express-scripts.com you can print Express Scripts Pharmacy Order Forms at your convenience. You can also order refills online.

Mail Order or Retail Pharmacy – How to Decide	
Mail Order Service	Retail Pharmacy
Up to a 90-day supply	Up to a 30-day supply
Use for long-term treatment (i.e., blood pressure, diabetes)	Use for short-term treatment (i.e., antibiotic, pain relievers)
No dispensing fee	Dispensing fee \$1.50 - \$2.00
Save at least an additional 7-8% more than retail for most brand-name drugs	Pay Express Scripts discounted retail price

Specialty Medicines and Therapies

Specialty medications including biotech injectables, infusibles and advanced oral drugs are available through Express Scripts' specialty medication pharmacy: Accredo pharmacy. Accredo pharmacy is a mail service pharmacy for specialty drugs. These drugs are generally used to treat chronic conditions such as HIV, hepatitis, rheumatoid arthritis, pulmonary disorders, growth hormone disorders and others. Express Scripts' specialty pharmacy prices may be lower than what you would pay at a retail pharmacy or through the mail order service. Each specialty pharmacy order is limited to a 30-day supply. Please note the following:

- As of January 1, 2020, all specialty drugs obtained under the pharmacy benefit will have to use Accredo mail service facility and no courtesy fills at retail will be permitted.
 - The only exception are drugs that require immediate use, which can be filled either at a retail pharmacy or at the Accredo mail service pharmacy.
 - Drugs that fall into this category include the following: Arixtra, Enoxaparin, Fondaparinux, Fragmin, Gamastan, and Lovenox.
- If an ESI mail pharmacy receives a script for a specialty drug they will route to Accredo pharmacy for dispensing.

For specific information, call Express Scripts' specialty pharmacy at 866-848-9870. For general information on specialty medications, visit www.express-scripts.com.

Specialty Pharmacy Copay Assistance Program

Effective January 1, 2020, the Plans include 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 option, 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 HRA1 or HRA2 medical options.

Also, manufacturer-funded copay assistance for widely distributed specialty drugs will not be considered as 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 www.express-scripts.com or the HR Portal at askHR.hersheys.com and search "specialty drug list".

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

Express Scripts Rx Clinical Management

You may encounter certain clinical programs to help manage the safety and costs of our prescription plan. You and/or your provider may need to provide additional information to Express Scripts for final approval under our plan. The clinical programs you may encounter are listed below. Keep in mind these are only for certain medications and therapies.

Step Therapy

Step Therapy is a program designed especially for people who take prescription drugs regularly to treat ongoing medical conditions, such as arthritis and high blood pressure. The program is a new approach to getting patients the prescription drugs they need, with safety, cost and — most importantly — their health in mind.

In Step Therapy, Express Scripts groups medications into two categories:

- **Step 1 medications:** These are the drugs recommended for you to take first — usually generic medications, which have been proven safe and effective. You pay the lowest coinsurance for these drugs.
- **Step 2 medications:** These are brand-name medications, like those you see advertised on TV. They're recommended for you to take only if a Step 1 medication doesn't work for you. You almost always pay more for brand-name medications.

Prior Authorization

Prior Authorization is a program that helps you get prescription drugs you need with safety. It helps you get the most from your healthcare dollars with prescription drugs that work well for you and that are covered by the pharmacy benefit. It also helps control the rising cost of prescription drugs for everyone in the plan.

The program monitors certain prescription drugs and their costs, so you can get the right prescription drug at the right cost. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed certain medication, it may need a "prior authorization." For instance, Prior Authorization ensures that covered prescription drugs are used for treating medical problems rather than for other purposes.

Example: A medication may be in the program because it treats a serious skin condition, but it could also be used for cosmetic purposes, such as reducing wrinkles. To make sure your medication is used to treat a medical condition and promotes your health and wellness, our plan may cover it only when a doctor prescribes it for a medical problem.

In this program, your own medical professionals are consulted. When your pharmacist tells you that your prescription needs a "prior authorization," it simply means that more information is needed to see if our plan can cover the prescription drug. Only your doctor (or sometimes a pharmacist) can provide this information and request a prior authorization.

Drug Quantity Management (DQM)

Drug Quantity Management (DQM) is a program that's designed to make the use of prescription drugs safer and more affordable. It provides you with medications you need for your good health and the health of your family, while making sure you receive them in the amount — or quantity — considered safe.

Certain medications are included in this program. For these medications, you can receive an amount to last you a certain number of days. For example, the program could provide a maximum of 30 pills for a medication you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S. Food & Drug Administration (FDA).

Drug Quantity Management also helps save money in two different ways: First, if your medication is available in different strengths, sometimes you could take one dose of a higher strength instead of two or more of a lower strength — which saves money over time. For example:

- You might be taking two 20 mg pills once a day. To last you a month, you need 60 pills. But Drug Quantity Management could provide just 30 pills at a time. You would need to get two supplies — and pay two coinsurance payments— every month.
- With your doctor's approval, you could get a higher strength pill. For instance, you could take a 40 mg pill once a day (instead of two 20 mg pills). One supply lasts you a month — and you have just one coinsurance payment.

Secondly, the program also controls the cost of “extra” supplies that could go to waste in your medicine cabinet.

For additional information on all the Express Scripts clinical programs and pharmacy protocol, contact Express Scripts at 877-309-6408 or www.express-scripts.com.

Drugs and Other Items that are not Covered

The following are not covered by the Plans:

- Drugs or medications from non-participating pharmacy providers
- Coinsurance you are required to pay under the plan
- Prescription drugs to which you are entitled under a government plan or program, state or federal workers' compensation laws and occupational disease laws and other employer liability laws
- Drugs prescribed for uses not approved by the Food and Drug Administration (FDA) **
- Any prescription for more than the retail days' supply or mail service days' supply allowed under the plan

- Drugs that require prior authorization, when authorization is not approved
- Any drug or medication that is not on the covered Prescription Drug list (i.e., Formulary)
- Drugs used for cosmetic purposes, including hair growth stimulants, depigmentation agents, photo-aged skin products, and injectable cosmetics. **
- Any drugs or supplies that can be purchased without a prescription order (or over the counter) including but not limited to blood glucose monitors, smoking cessation products, injection aids, non-legend medication unless otherwise specified herein. This does not apply to over the counter drugs that are covered as preventive care.
- Food supplements (including Ensure, SlimFast, sports nutrition supplements, homeopathic medicines, fish & animal oils, herbal food supplements, etc.)
- Allergens
- Legend homeopathic drugs
- Durable medical equipment
- Immunization agents and biologicals, except for immunizations covered for preventive services
- Charges for therapeutic devices or appliances (e.g., support garments and other nonmedicinal substances)
- Any prescription drug which is experimental/investigational in nature
- Prescription drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein
- Blood products

** *Some medications have prior authorization criteria allowing coverage.*

Filing Medical Claims

Generally, when you receive care from a network provider, you do not have to file claim forms. Present your Highmark ID card when you receive medical services, and your provider will file the claims for you.

If you receive care from an out-of-network provider, you or the provider must file a claim for reimbursement. Claim forms are available online at www.highmarkblueshield.com. Complete the claim form and send it to Highmark Blue Shield at:

Highmark Blue Shield
P.O. Box 890382
Camp Hill, PA 17089-0382

You must include an original itemized bill or receipt. Make a copy of the receipt for your records, since Highmark Blue Shield will not return the original to you. Bills or receipts must show:

- Provider's name and address
- Patient's name, address and date of birth
- Date of service(s)
- Diagnosis or nature of illness
- Description of services performed
- Charge for each service
- For durable medical equipment, the doctor's certification
- For private duty nursing, the nurse's license number, charge per day and shift worked
- For ambulance services, the total mileage

If you have already paid for services, you must also submit proof of payment (receipt from the doctor) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

Timely Filing Requirements

Unless otherwise specified in the Plans or this summary plan description, you or your dependent(s) must file an initial claim for medical benefits within 12 months from the date of service. You must use a separate form for each patient. You or your dependent(s) must complete the required claims and appeals process described in the Claims Denials and Appeals section before you may bring legal action or, where applicable, pursue external review. You may not file

a lawsuit for benefits if the initial claim or appeal is not made within the time periods described in the Claims Denials and Appeals section.

You must file any lawsuit for benefits within 1 year after the final decision on appeal. You may not file suit after the 1-year period expires. You or your dependent(s) are not required to request voluntary internal review or an external review before filing a lawsuit. If you or your dependent(s) do request voluntary internal review or an external review of the decision on appeal, the time taken to under the voluntary review process will not be counted against the 1 year in which you have to file a lawsuit.

Your Explanation of Benefits (EOB) Statement

After your claim is processed, you may receive an Explanation of Benefits (EOB), statement, either online or in the mail, from Highmark Blue Shield. The statement lists:

- The provider's charge
- Allowable charge
- Deductible and coinsurance amounts
- Total benefits payable by the plan
- The total amount you owe the provider

An EOB is not a bill. If there is an amount you owe the provider, you will be billed for it separately.

Administrative Information

There is certain information that you may need to know about the medical and prescription drug benefits under the Plans. This information is summarized in this section.

General Plan Information

The medical and prescription drug benefits are part of The Hershey Company Health and Welfare Plan for Active and Inactive Employees (Plan Number 506) and The Hershey Company Retiree Medical and Life Insurance Plan (Plan Number 550). The Plan Year is a calendar year, beginning on January 1 and ending on December 31. The medical and prescription drug benefits under the Plans are self-insured, meaning that benefits are paid through a combination of employee contributions and Employer contributions from the company's general assets. The third-party claims administrator processes claims but is not responsible for payment of benefits. The medical and prescription drug benefits under the Plans are a type of health and welfare benefit.

Plan Sponsor Information

The Plan Sponsor's name, address, telephone number and Employer Identification Number (EIN) are:

The Hershey Company
19 East Chocolate Avenue
P.O. Box 810
Hershey, PA 17033-0810
800-878-0440
EIN 23-0691590

Plan Administrator Information

The name, address and telephone number of the Plan Administrator are:

Employee Benefits Administrative Committee (EBAC)
The Hershey Company
19 East Chocolate Avenue
P.O. Box 810
Hershey, PA 17033-0810
800-878-0440

Service of Legal Process

The name, address and telephone number of the Plans' agent for service of legal process are:

General Counsel
The Hershey Company
19 East Chocolate Avenue
P.O. Box 810
Hershey, PA 17033-0810
717-534-4200

Service of legal process may also be made on the Plan Administrator.

Plan Documents

The Employee Retirement Income Security Act (ERISA) requires the Plan Administrator to provide summary plan descriptions (SPDs) that explain the benefits and features of the Plan as simply, understandably and accurately as possible. Each benefit described in an SPD is also governed by a legal Plan document or contract. The formal plan documents for the Plans are "The Hershey Company Health and Welfare Plan for Active and Inactive Employees" (for Actives/Disabled) and "The Hershey Company Retiree Medical and Life Insurance Plan" (for Retirees). If the wording in this summary and the Plan document disagree, the Plan document will govern.

Plan Administration

The Plans are administered by The Hershey Company Employee Benefits Administrative Committee, which has the authority to delegate the day-to-day administrative duties. The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the plan options, programs and policies described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the plan options, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service providers.

If you have questions or comments regarding the Plans' administration, please call 800-878-0440.

Claims Administration

Your medical claims are administered by:

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

Your prescription drug claims are administered by:

Express Scripts, Inc.
Member Reimbursements
P.O. Box 66583
St. Louis, MO 63166
Attention: Claims Department
877-309-6408 (TDD 800-899-2114)
www.express-scripts.com

Other Legal Information

Applicable Law

The Plans and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of the Pennsylvania without giving effect to its conflicts of laws provision. The Plans may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

Assignment of Benefits

You may not assign your legal rights or rights to any payments under these Plans. However, the Plans may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under these Plans and have no rights to receive benefits from the Plans or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

Coordination of Benefits (COB)

If both you and your spouse or domestic partner work, members of your family could be covered under other group medical, vision and dental plans, in addition to the Company’s Plans. The coordination of benefits (COB) provision is designed to eliminate any duplicate payments for the same expenses. The intent of COB is not to pay the full cost of the health care expense, but to eliminate duplicate payments. In most cases, you will still be responsible for deductibles and coinsurance.

How COB Works

The COB provision determines which plan will pay benefits first and which will pay benefits second. The plan that pays first is called the primary plan. If you are an employee of the Employer enrolled in the Employer’s benefits, that plan is your primary plan. Your spouse’s employer-sponsored plan is his or her primary plan. Each of you should submit claims to your primary plan first. Then, what is not covered may be submitted to the secondary plan.

The secondary plan typically pays the difference between the primary plan’s benefit and the benefit the secondary plan would pay if there were not a primary plan. The primary and secondary plans may have different COB provisions, so it’s helpful to look at both plan summaries. Below is an overview of how the COB provision works:

- When your other medical coverage does not mention “coordination of benefits”, then that medical coverage pays first. Benefits paid or payable by the other medical coverage will be considered to determine if additional benefit payments can be made under your plan.
- When the person who received medical care is covered as an employee under one contract and as a dependent under another, the employee medical coverage pays first

- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. However, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following rules apply:
 - The parent with custody of the child pays first
 - The coverage of the parent with custody pays first but the stepparent's medical coverage pays before the coverage of the parent who does not have custody
 - Regardless of which parent has custody, if a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first
- When none of the above circumstances applies, the medical coverage you had for the longest time pays first provided:
 - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such a person shall be determined before the benefits of a plan covering this person as a laid-off or retired employee or as a dependent of such person. If the other plan does not have this provision regarding laid-off or retired employees, and as a result, plans do not agree on the order of benefits, then this rule is disregarded.

When a Covered Person Qualifies for Medicare

To the extent permitted by law, these Plans will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. The Plans pay benefits first and Medicare pays benefits second in the following circumstances:

- If you Are Under Age 65 With End Stage Renal Disease (ESRD)
- If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plans will provide the benefits described in this Summary Plan Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional 30 months after the Medicare effective date. After 33 months, the benefits described in this Summary Plan Description will be reduced by the amount that Medicare allows for the same covered services.
- If you Are Under Age 65 With Other Disability

- If you are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plans will provide the benefits described in this Summary Plan Description before Medicare benefits. This is the case only if you are actively employed by the Company or are the covered dependent of an actively employed plan participant. If you take a medical leave of absence, retain coverage under the Plans, and start receiving disability benefits from the Company, the plans will continue to pay primary for the first 6 months of your disability coverage, i.e., while disability benefits are subject to FICA tax. After this 6-month period, Medicare will become primary.
- If you Are Age 65 or Older
- If you are age 65 or older and eligible for Medicare only because of age, the Plans will provide the benefits described in this Summary Plan Description before Medicare. This can be the case only if you are actively employed by the Company or are the covered dependent of an actively employed Plan participant.
- Leave of Absence
- If you take a leave of absence and retain coverage under the Plans, the Plans will continue to pay primary for as long as you retain your right to return to active employment (i.e., your employment is not terminated by the Company). If your employment is terminated by the Company, Medicare will become primary.

Coordination of Benefits for Children/Qualified Medical Child Support Order

If your children are covered under the plans of both parents, the parent whose birthday falls earlier in the calendar year will have the primary plan for the children. When parents are divorced or separated, the parent with custody of the children usually has the primary plan, unless the noncustodial parent has been assigned responsibility for the children's health care through a Qualified Medical Child Support Order ("QMCSO") or another court decree.

A QMCSO creates or recognizes the right of a child who is covered by the QMCSO to be enrolled in, and to receive benefits under, a group health plan for which the employee is eligible and includes the name and last known address of the employee and such child, a reasonable description of the type of coverage to be provided, and the period for which coverage must be provided. If you are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Company or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Coordination with Auto Insurance

If you are injured in an automobile accident, the Plans will coordinate benefits with the auto insurance policy. The Plans will pay the difference between what the auto insurance policy pays and the amount the Plans would have paid if it were your only health care coverage.

To Prevent Duplicate Payments – Subrogation and Reimbursement

If you are injured as a result of someone else's negligence or wrongdoing, the Plans may recover benefit payments for care related to your injury. This right is known as subrogation. The Plans may subrogate or substitute for you in trying to recover payment from the negligent party. If you do not take legal action against the responsible person or their insurance company, the Plans may do so in your name. If you do pursue legal action, the Plans is not required to, but may participate in that action. The Plans may recover payment from the responsible party, the insurance carrier or from you if you have been paid directly.

For instance, if you are injured in an automobile accident that was someone else's fault, you might receive payment from that person or from their automobile insurance company. If the Plans paid benefits for your medical expenses related to those same injuries, it can recover those benefits from you.

The Plans maintains a right to be repaid first from any recovery even if you are not made whole, or if you receive less than you believe to be the full value for your injuries. A constructive trust applies to any payment you receive from a third party or insurance company. This means you are obligated to hold that payment and immediately reimburse the Plans before spending, saving, or transferring the payment to someone else. The Plans are not responsible for any costs you may incur in recovering a payment from a third party, such as attorneys' fees or other out-of-pocket expenses.

You specifically agree not to do anything to prejudice the Plans' right to subrogation or reimbursement. In addition, you and your eligible dependents agree to cooperate fully with the Plans and the Company in asserting and protecting the Plans' subrogation and reimbursement rights. You agree to execute and deliver all instruments and papers (in their original form) and do what is necessary to fully protect the Plans' subrogation and reimbursement rights. You agree to notify the Company in writing whether benefits are paid under the Plans that arise out of any injury or illness that provides or may provide the Plans subrogation or reimbursement rights pursuant to this subrogation provision. Furthermore, you specifically agree to notify the Plans within 30 days of the date of any notice is given by any party of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained illness or injury.

Overpayments or Mistaken Payments

The Plans have the right to recover any overpayments or mistaken benefit payments. Such payments may happen if the Plans have not received accurate information about the medical service or the patient's eligibility for benefits, or while you are waiting for approval or settlement of Workers' Compensation or other insurance benefits. The Plans may deduct the amount of overpayments or mistaken payment from any future amounts due to you under the Plans, or bring an action against you in court.

Claims Processing and Questions

All inquiries regarding benefits, including any claims for benefits, should be directed to the claims administrator. You must submit a claim, in writing, supported by the proper documentation. The claims administrator will supply you with the appropriate forms and procedures. Your benefit claim will be processed according to the procedures described in this summary. It is important to follow these procedures carefully to ensure efficient response to your claim and to protect your rights under the plan and under the law, if a claim is denied. If you are unable to resolve your claim dispute and decide to file a lawsuit, you must have followed each step outlined here within the required time limits.

Any written inquiries regarding your entitlement to or the amount of your benefit, forms of payment, spousal consent requirements or when benefits begin will receive a written response within 30 days of receipt of your inquiry. A formal claim will receive written response within 90 days following receipt of the claim.

Verbal inquiries will receive a verbal response.

Claims Denials and Appeals

At any time during the claims and appeal process, you may choose to designate a representative to participate in the claims and appeal process on your behalf.

Claims Process

You or your dependent(s) must file an initial claim for medical benefits within 12 months from the date of service. Your claim for benefits will be processed under the procedures described below.

Urgent Claims

An “urgent claim” is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

Notice of a Plan's determination will be sent as soon as possible taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.

Pre-Service Claims

A pre-service claim is a claim for services that have not yet been rendered and for which a Plan requires prior authorization.

If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim.

If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim.

If the claims administrator determines that an extension is necessary due to matters beyond control of a Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The claims administrator then will make its determination within 15 days from the date a Plan receives your information, or, if earlier, the deadline to submit your information.

Post-Service Claims

A post-service claim is a claim for services that already have been rendered, or where a Plan does not require prior authorization.

Notice of a Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim.

If the claims administrator determines that an extension is necessary due to matters beyond control of a Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The claims administrator then will make its determination within 15 days from the date a Plan receives your information, or, if earlier, the deadline to submit your information.

Concurrent Care Claims

A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care.

You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan amendment or termination of a Plan.

At any time during the claims or appeal process, you may contact member services at the toll-free telephone number listed on your ID card to inquire about the filing or status of your claim or appeal.

If your claim for benefits is denied in whole or in part, the claims administrator will notify you in writing. This written notice will include:

- Specific reason(s) for the denial, and information sufficient to identify the claim involved
- References to plan provision(s) on which the denial is based
- Description of any additional material or information that is necessary to correct the claim and an explanation of why such material or information is necessary
- Procedures for appealing the decision and a statement of your right to bring a civil action under section 502(a) of ERISA following appeal;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making the determination
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process
- If the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination (or a statement that such information will be provided free of charge upon request);
- The denial code and corresponding meaning;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning
- A description of the claims administrator's standard, if any, used in denying the claim
- A description of the external review process, if applicable

Appeals Process

Our medical plans maintain an appeal process involving two levels of review with the exception of urgent care claims (which involve a single level of review).

First Level Appeal

You or your authorized representative may review all documents related to any denial of benefits. If you disagree with the claims administrator's decision, you have 180 days from the receipt of the original denial to request a review and appeal the decision.

If your claim is denied, you may send an appeal in writing to the claims administrator, explaining your reasons for appealing the decision. Your appeal will be reviewed by a representative who was not involved in any previous adverse decision regarding the request, who is not a subordinate of any individual involved in any previous adverse decision and who does not afford deference to the initial adverse benefit determination.

In rendering a decision on the appeal, the claims administrator will take into account all evidence, comments, testimony, documents, records, and other information submitted without regard to whether such information was previously submitted to or considered by the claims administrator. For appeals related to medical necessity, experimental or investigational requests, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the request. The health care professional will be a person who was not involved in any previous adverse decision regarding the subject of the appeal and is not the subordinate of any person involved in the previous adverse decision. You have the right to request identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Before the Plan issues a decision on the first level appeal, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal decision is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Before the Plan issues a decision on the first level appeal based on a new or additional rationale, the Plan will provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal decision is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Non-urgent pre-service appeal requests will be reviewed, and a decision made within fifteen (15) days from receipt of the request. Non-urgent post-service appeal requests will be reviewed, and a decision made within thirty (30) days from receipt of the request. Urgent appeal requests will be reviewed, and a decision made within seventy-two (72) hours from receipt of the request, and appropriate physician authorization.

Second Level Appeal

If your claim is not accepted during the first level appeal (other than the review of an urgent care claim), you or your authorized representative may request a second level review in writing within forty-five (45) days from receipt of the first level decision letter.

As with the first level appeal, the claims administrator will take into account all comments, documents, records, and other information submitted without regard to whether such information was previously submitted to or considered by the claims administrator. The claims administrator representative will be someone not involved in the first level review. For appeals related to medical necessity, experimental or investigational requests, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the request. The health care professional will be a person who was not involved in any previous adverse decision regarding the subject of the appeal and is not the subordinate of any person involved in the previous adverse decision.

Before the Plan issues a decision on the second level appeal, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal decision is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Before the Plan issues a decision on the second level appeal based on a new or additional rationale, the Plan will provide you, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal decision is required to be provided, to give you a reasonable opportunity to respond prior to that date.

Non-urgent pre-service appeal requests will be reviewed, and a decision made within fifteen (15) days from receipt of the request. Non-urgent appeal requests and post-service claim appeals will be reviewed, and a decision made within thirty (30) days from receipt of the request.

For both the first and second level appeal, the decision letters will include:

- The decision
- The specific reason or reasons for the decision
- Reference to the specific plan provisions or contractual basis on which the decision is based
- A statement describing any additional levels of appeal and appropriate contact
- A statement advising you and/or your authorized representative you are entitled to receive, upon request and free of charge, a copy of all documents, records and other information relevant to your claim for benefits

- A statement regarding your right to request an external review for a post-service claim and of your right under section 502 (a) of the ERISA Act of 1974 to file civil action contesting this adverse benefit determination
- Any internal rule, guidelines, or protocol relied on in making the adverse determination (or statement that such information will be provided free of charge upon request);
- If the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment for the determination (or a statement that such information will be provided free of charge upon request);
- Information sufficient to identify the claim involved
- The denial code and corresponding meaning;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning
- A description of the claims administrator's standard, if any, used in denying the claim
- A description of the external review process, if applicable
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process

If you disagree with the claims administrator's decision, you may have the right to bring civil action under section 502(a) of ERISA. You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor (DOL) Office.

External Review

If, after exhausting your internal appeals, you are not satisfied with your final determination, and that denial is based on (1) clinical reason/medical judgment; (2) a determination that a treatment is experimental or investigational or based on unproven services; (3) rescission of coverage (coverage that was cancelled or discontinued retroactively); or (4) as otherwise required by applicable law, you may request an external review. You have four months from the date you receive notice of a final adverse benefit determination to file a request for an external review with the claims administrator. Note that for Pre-Service Claims, the four month period begins to run from the date you received the claims administrator's first-level adverse benefit determination.

The external review process offers an independent review of the denial of a requested service or procedure or the denial or payment for a service or procedure. The process is available to you at no charge after exhausting the appeals process identified above and

you receive a decision that is unfavorable, or if the claims administrator fails to respond to your appeal in accordance with applicable regulations.

Preliminary Review

The claims administrator will conduct a preliminary review of your external review request within five business days following the date on which the claims administrator receives the request. The claims administrator's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

The claims administrator will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, the claims administrator's notification will describe the information or materials needed to make the request complete. You will then have the balance of the 4-month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

Referral to an Independent Review Organization (IRO)

The claims administrator will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request is found acceptable after preliminary review. An IRO is an independent organization of medical experts who are qualified to review medical and other relevant information. The IRO, which will have no material affiliation or interest with the claims administrator or the Employer, will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, the claims administrator will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse the claims administrator's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you within at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your Claim *de novo*. In other words, the IRO will not be

bound by any decisions or conclusions reached by the claims administrator during the above-described first and second-level appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and the claims administrator. The IRO's notice will inform you of:

- A general description of the reason for the external review request, including information sufficient to identify the claim;
- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon the claims administrator's receipt of the IRO's notice of a final external review decision from the IRO that reverses the claims administrator's prior final internal adverse benefit determination.

[Expedited External Review](#)

You are entitled to the same procedural rights to an external review as described above on an expedited basis if:

- The final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you

received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, the claims administrator will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, the claims administrator's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

The claims administrator will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, the claims administrator will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your Claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached by the claims administrator during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to the claims administrator, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- A general description of the reason for the external review request, including information sufficient to identify the claim;
- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon the claims administrator's receipt of the IRO's notice of a final external review decision from the IRO that reverses the claims administrator's prior final internal adverse benefit determination.

Statement of ERISA Rights

As a participant in The Hershey Company Health and Welfare Plan for Active and Inactive Employees or The Hershey Company Retiree Medical and Life Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you will be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file a lawsuit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Word about HSAs

Health Savings Accounts (HSAs) are not subject to ERISA but they are offered with the HSA medical plan. Although the Preferred Provider Organization (PPO) benefits component of the HSA medical plan is subject to ERISA rights and responsibilities, the HSA itself is not. Plan members are responsible for keeping track of eligibility, contributions and utilization of their HSA accounts, in addition to the tax consequences of an HSA.

Reservation of Rights

The Company reserves the right to amend or terminate the Plans and any benefits under them at any time. If such steps are taken, you will be notified. You will also be informed of the effect that any material changes to the Plans will have on your rights to benefits. Neither the Plans nor the benefits described in this Summary Plan Description can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by any delegate of the Plan Administrator, or by Employer management. Only written statements by the Plan Administrator or its delegates, issued in accordance with the delegation of authority, shall bind the plan.

Important Notice

While every effort has been made to ensure the accuracy of the information in this booklet, the Company reserves the right to correct all errors. This booklet should not be considered to be a guarantee of future employment with the Employer. In addition, the Company reserves the right to amend or terminate the Plans and any benefits under them at any time.

Appendix A

The following Affiliates have adopted the Plans:

The Hershey Sourcing Company
The Hershey Sales Company
Amplify Snack Brands, Inc.
CSH Foods, Inc.
Hershey Chocolate of Virginia, Inc.
Hershey Chocolate & Confectionery Corp.
The Hershey Licensing Company