

# **The Hershey Company Retiree Medical and Life Insurance Plan**

(For Medical and Prescription Drug benefits for Retirees  
Age 65 and Over)

## **Summary Plan Description (SPD)**

Effective 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](mailto:askhr@hersheys.com), 800-878-0440 or 717-534-8170.



## Table of Contents

<b>Introduction</b> .....	<b>1</b>
Overview .....	1
Plan Contact Information.....	1
<b>Administrative Information</b> .....	<b>2</b>
<b>Glossary</b> .....	<b>3</b>
<b>Article 1 Eligibility and Enrollment</b> .....	<b>9</b>
Eligible Retirees .....	9
Surviving Dependents of Retired Employees.....	9
Newly Eligible Retirees.....	10
Open Enrollment.....	10
Mid-Year Changes: Qualified Medical Child Support Orders.....	10
Mid-Year Changes: HIPAA Special Enrollment Events.....	10
Mid-Year Changes: Change in Status Events.....	10
<b>Article 2 Retiree Contributions</b> .....	<b>11</b>
<b>Article 3 When Your Coverage Ends</b> .....	<b>12</b>
When Coverage Ends .....	12
Rescission in Event of Fraud .....	12
<b>Article 4 COBRA Continuation Coverage</b> .....	<b>12</b>
When You May Elect COBRA Coverage .....	13
Applying for COBRA Coverage .....	13
When COBRA Coverage Ends.....	13
COBRA coverage will end if: .....	13
<b>Article 5 Filing Claims and Appeals</b> .....	<b>14</b>
Claims and Appeals .....	14
Deadline to Bring Legal Action.....	14
<b>Article 6 Other Legal Information</b> .....	<b>14</b>
Coordination of Benefits .....	14
Right of Recovery/Subrogation .....	14
Applicable Law.....	14
Plan Amendment & Termination .....	14
Merger or Consolidation.....	15
Assignment of Benefits .....	15
Missing Persons.....	15
Right to Recover Overpayment .....	15
<b>Article 7 Legal Notices</b> .....	<b>16</b>

Newborns' & Mothers' Health Protection Act.....16  
Statement of ERISA Rights.....16  
Receive Information About the Plan .....16  
Prudent Actions by Plan Fiduciaries .....16  
Enforce Your Rights.....17  
Assistance with Your Questions.....17  
The Hershey Company Notice of Privacy Practices .....17  
Purpose .....17  
Your Rights.....20  
Complaints.....21  
Plan Contact Information.....22

**Appendix A.....23**

**Appendix B.....24**



## Introduction

### Overview

The Hershey Company Retiree Medical and Life Insurance Plan (the “Plan”) is an employer-sponsored health and welfare employee benefit plan. This Summary Plan Description describes the medical and prescription drug benefits under the Plan for eligible retirees who are age 65 and older.

A detailed list of benefit types provided under the Plan, along with contact information and more information about how to access the Insurance Policies/Evidence of Coverage describing these benefits, can be found at Appendix A. Unless otherwise noted in Appendix A, the benefits under the Plan are governed under ERISA.

The terms and conditions of the Plan are set forth in this Summary Plan Description, the formal Plan Document, and the Insurance Policies/Evidence of Coverage related to the benefits under the Plan. Together, these documents are incorporated by reference into the formal Plan Document and constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

This summary should be read in connection with the Insurance Policy/Evidence of Coverage provided by the Insurer listed at Appendix A. Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and an Insurance Policy/Evidence of Coverage, or this Summary Plan Description, the Plan Document controls. If the Plan Document is silent, then the Summary Plan Description controls, except where the Summary Plan Description refers to an Insurance Policy/Evidence of Coverage. If both the Plan Document and Summary Plan Description are silent, the terms of the Insurance Policy/Evidence controls. However, the terms of the certificate of insurance coverage or Insurance Policy/Evidence of Coverage control when describing specific benefits that are covered or insurance-related terms.

The Hershey Company reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time for any reason at its sole discretion.

### Plan Contact Information

Questions concerning this Plan can be directed to the Plan Administrator listed in the Administrative Information section or the Insurer listed at Appendix A.

## **Administrative Information**

<b>Plan Name &amp; Number</b>	The Hershey Company Retiree Medical and Life Insurance Plan (550)
<b>Plan Sponsor</b>	The Hershey Company 19 East Chocolate Avenue P.O. Box 810 Hershey, PA 17033-0810 800-878-0440
<b>Plan Sponsor's Employer Identification Number</b>	23-0691590
<b>Plan Administrator</b>	Employee Benefits Administrative Committee (EBAC) The Hershey Company 19 East Chocolate Avenue P.O. Box 810 Hershey, PA 17033-0810 800-878-0440
<b>Agent for Service of Legal Process</b>	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.
<b>Plan Year</b>	January 1 – December 31
<b>Plan Type</b>	Medical and prescription drug benefits
<b>Administration &amp; Funding</b>	All benefits are fully insured and are administered by the Insurer listed at Appendix A. Benefits will be paid out of the Insurance Policies listed at Appendix A.
<b>Source of Contributions</b>	Contributions will be paid out of the Employer's general assets and through contributions paid by Eligible Retirees, in the amounts determined by the Employer in its discretion.

## Glossary

### COBRA

The Consolidated Omnibus Budget Reconciliation Act, which provides continuation coverage for certain benefits when an Eligible Retiree or Eligible Dependent has experienced a loss of coverage due to a qualifying event.

### Company

The Hershey Company, a Delaware corporation

### Dependent Child

A dependent child of the Eligible Retiree who is under the age of 26 and who is:

- a natural child;
- an adopted child or a child placed for adoption;
- a stepchild;
- a foster child; or
- a child for whom an Eligible Retiree or Domestic Partner has legal custody or legal guardianship, provided that the child is (a) related to the Eligible Retiree or is living as a member of the Eligible Retiree's household, (b) the Eligible Retiree provides more than half of the child's support; and (c) for federal tax purposes, not a dependent of a taxpayer other than the Eligible Retiree.

A Dependent Child also includes an unmarried child of any age, if the child is mentally or physically incapable of self-support and was covered by this Plan or, with respect to new hires, another group health plan, immediately prior to the onset of the disability, provided that the child is (a) related to the Eligible Retiree or is living as a member of the Eligible Retiree's household, (b) the Eligible Retiree provides more than half of the child's support; and (c) for federal tax purposes, not a dependent of a taxpayer other than the Eligible Retiree.

### Domestic Partner

The Plan defines 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 Plan, 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 contact the **HR Support Center** at 800-878-0440.

**Eligible Dependent**

An individual who meets the eligibility requirements described in Article 1 of this SPD, “Eligible Dependents.”

**Eligible Retiree**

A retired employee of the Employer who meets the eligibility requirements described in Article 1 of this SPD, “Eligible Retirees.”

**Employer**

The Company and any Affiliate that adopts the Plan in accordance with the formal Plan documents, or any successor to the Company or any such Affiliate, and is listed in Appendix B.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

**HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.



<b>Insurance Policy</b>	The policies provided by the Insurer listed at Appendix A that describe the fully insured benefits under the Plan. The terms of the Insurance Policies are described in an Evidence of Coverage.
<b>Insurer</b>	The insurance company listed at Appendix A that the Employer has contracted with to provide insurance coverage. The Insurer processes your claims with respect to the Plan’s medical and prescription drug benefits. These benefits are paid by the Insurer under the terms of the Insurance Policy.
<b>Internal Revenue Code or Code</b>	The Internal Revenue Code, as amended from time to time.
<b>Open Enrollment</b>	The annual enrollment opportunity designated by the Plan Administrator.
<b>Participant</b>	An individual who has satisfied the Plan’s eligibility requirements and has elected to participate in the Plan.
<b>Plan</b>	The Hershey Company Retiree Medical and Life Insurance Plan (550)
<b>Plan Administrator</b>	The Employer or person or entity that the Employer designates to perform specific administrative duties under the Plan.
<b>Plan Document</b>	The formal wrap plan document that, along with this Summary Plan Description and Insurance Policies/Evidence of Coverage, constitutes the plan document for purposes of ERISA. The Plan Document includes information on plan administration, delegation, and amendment authority. The Plan Document for the Plan is “The Hershey Company Retiree Medical and Life Insurance Plan – Amended and Restated Effective as of January 1, 2017.”
<b>Plan Year</b>	The twelve-month period selected by the Employer to be the Plan Year. The Plan Year for the Plan is January 1 – December 31.
<b>Qualified Medical Child Support Order (QMCSO)</b>	A final court or administrative order requiring an Eligible Employee to provide health care coverage for a Dependent Child, usually following a divorce or child custody proceeding, as defined in section 609(a)(2)(A) of ERISA.

**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.

**Spouse**

An individual who is lawfully married to an Eligible Retiree 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.

**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

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.

### Summary Plan Description (SPD)

This booklet, which describes terms that apply to the benefits under the Plan available to eligible retirees who are age 65 and older, and, when combined with the Insurance Policies/Evidence of Coverage provided by the applicable Insurers, constitute the Summary Plan Description that is required under ERISA.



## 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 Hershey 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

## 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 described in Article 1 of this SPD. 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.



## Article 1 Eligibility and Enrollment

### Eligible Retirees

RME Individuals and SRC Individuals who retire from the Employer are eligible for the medical and prescription drug benefits described in this Summary Plan Description, as long as they:

- Terminate employment with the Employer at or after age fifty-five (55) and after completing five (5) Years of Service with the Employer;
- Have attained age sixty-five (65) or older;
- Are enrolled in both Medicare Part A and Part B benefits; and
- Do not have End-Stage Renal Disease (“ESRD”), with limited exceptions described in more detail in the Evidence of Coverage.

If a salaried or non-union hourly Eligible Retiree is an eligible dependent of an eligible employee under The Hershey Company Health and Welfare Plan for Active and Inactive Employees (“Active and Inactive Plan”), the Eligible Retiree must elect coverage under the Active and Inactive Plan as an eligible dependent, rather than as a retired employee under this Plan.

- Eligible Dependents
- If you are an Eligible Retiree, you may also enroll the following dependents in the medical and prescription drug benefits described in this Summary Plan Description:
  - Your Spouse or Your Domestic Partner; and
  - Your Dependent Child and/or your Domestic Partner’s Dependent Child.
- In order to be eligible for benefits under the Plan, your dependents must also:
  - Be enrolled in both Medicare Part A and Part B benefits;
  - Not have End-Stage Renal Disease (“ESRD”), with limited exceptions described in more detail in the Evidence of Coverage.

### Surviving Dependents of Retired Employees

Dependents of a deceased Eligible Retiree may be eligible for the medical and prescription drug benefits under the Plan in certain circumstances. See the Plan Document for the rules regarding surviving dependents. You can receive a copy of this document by contacting the **HR Support Center** at 800-878-0440.

## 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 enroll or change elections during the Plan’s annual Open Enrollment period, in accordance with procedures established by the Employer in its sole discretion. Your elections will remain effect for the remainder of the Plan Year, unless you experience an event allowing a mid-year change, as described below.

## Mid-Year Changes: 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) and the child is otherwise eligible (*i.e.* enrolled in Medicare). A QMCSO is a court order that requires you to provide health coverage to your children. You may obtain a copy of the Employer’s procedures for QMCSO determinations, free of charge, by contacting the Plan Administrator.

## Mid-Year Changes: HIPAA Special Enrollment Events

If you decline enrollment for the medical and prescription drug benefits under the Plan for yourself or your Eligible Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Eligible Dependents in the medical and prescription drug benefits under this Plan mid-year if you or your Eligible Dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your Eligible Dependents’ other coverage). However, you must request enrollment within 31 days after your Eligible Dependents’ other coverage ends (or after the other employer stops contributing toward the other coverage).

To request enrollment under these HIPAA special enrollment rules or to obtain more information, including possible extensions of time for enrollment in certain circumstances, contact the Plan Administrator.

## Mid-Year Changes: Change in Status Events

You also may change certain elections mid-year if you experience a change in status event listed below. You must notify the Plan Administrator within 31 days in order to make a change in your election during the year. The notice must be in writing, on the form required by the Employer, with supporting documentation. Where applicable, the changes you make to your coverage must be consistent with and “on account of and correspond with” the event. For example, if your child



no longer is eligible for medical and prescription drug benefits, you may cancel medical and prescription drug coverage only for that child, not yourself or your Spouse.

- Legal marital status: Any event that changes your legal marital status, including marriage, divorce, death of a Spouse, legal separation, and annulment.
- Change in domestic partnership status: Commencement or dissolution of a domestic partnership.
- Number of Eligible Dependents: Any event that changes your number of Eligible Dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- Employment status: Any event that changes your or your Eligible Dependents' employment status that results in gaining or losing eligibility for coverage.
- Dependent Status: Any event that causes your Eligible Dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.
- Residence: A change in the place of residence for you or your Eligible Dependents if the change results in you or your Eligible Dependents living outside the network service area of your medical and prescription drug coverage.
- HIPAA Special Enrollment Event: The events listed above as HIPAA Special Enrollment events.
- Entitlement to Medicaid: If you or your Eligible Dependents become entitled to or lose entitlement to Medicaid.
- Judgment, Decree, or Order: If a judgment, decree or order, such as a QMCSO, requires your Dependent Child to be covered under this Plan (or another plan).
- Significant Change in Coverage: If the cost of coverage is significantly increased or decreased, or if benefits are significantly improved or curtailed.

## **Article 2**

### **Retiree Contributions**

You and the Employer share the cost of your benefits. Information describing your share of the cost for each option will be available at enrollment. See the Plan Document for the rules regarding contributions for the medical and prescription drug benefits. You can receive a copy of this document by contacting the **HR Support Center** at 800-878-0440.

## **Article 3**

### **When Your Coverage Ends**

#### When Coverage Ends

Your coverage under the Plan will end on the earlier of:

- The last day of the month that you are no longer an Eligible Retiree;
- The date you fail to make any required contributions or monthly payments; or
- The date the Plan is amended to no longer provide a particular benefit or is terminated.
- An Eligible Dependent's coverage under the Plan will end on the earlier of:
  - The last day of the month that he or she is no longer an Eligible Dependent;
  - The date your coverage ends; or
  - The date the Plan is amended to no longer provide a particular benefit or no longer offers coverage for dependents.
- Under some circumstances, you or your Eligible Dependents may continue coverage through COBRA continuation coverage. See the COBRA section.

#### 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 Plan, and the Plan may rescind coverage retroactively as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, may invalidate any payment or claims for services and may be grounds for rescinding coverage.

## **Article 4**

### **COBRA Continuation Coverage**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of medical and prescription drug coverage for "qualified beneficiaries" who lose their coverage due to a "qualifying event." You (or your Eligible Dependent) must be offered the same medical and prescription drug coverage that you had the day before the qualifying event that caused you to lose coverage.

The cost of COBRA coverage will be the full cost of coverage (the employer plus employee portion), plus a 2% administrative fee. When you enroll, you will receive a separate notice that gives more information on your COBRA rights. You also will receive an election notice if you experience a qualifying event. For more information, please contact the Plan's COBRA administrator.



## When You May Elect COBRA Coverage

You may continue coverage for yourself until your death, and your covered Eligible Dependents for up to 36 months, following the date of your death (in the event that your former Employer terminates your coverage in connection with a bankruptcy proceeding under title 11 of the United States Code or substantially eliminates your coverage within one year before or after the commencement of the proceeding).

Your covered Eligible Dependents may elect to continue coverage for up to 36 months if coverage ends for one of the following reasons:

- Your death;
- Your divorce or legal separation; or
- Your covered Dependent Child no longer meets the eligibility requirements under the Plan.

## Applying for COBRA Coverage

When your coverage ends, you or your Eligible Dependents have 60 days to elect continued coverage. The 60 days is counted from the day your benefits end or the date your COBRA notice is mailed, whichever is later.

In the case of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you or your Eligible Dependent must notify the COBRA administrator within 60 days. Your dependents will not be eligible for COBRA coverage unless you notify the COBRA administrator that they have lost eligibility for coverage.

## When COBRA Coverage Ends

COBRA coverage will end if:

- the Employer stops providing coverage for all employees;
- You or your Eligible Dependents do not pay your premiums on time; or
- You or your Eligible Dependents become covered by another group health plan.

## **Article 5**

### **Filing Claims and Appeals**

#### Claims and Appeals

Each claim for benefits under the Plan must be filed in accordance with the procedures set forth in the Insurance Policy/Evidence of Coverage. All claims for benefits must be duly filed no later than the deadline set forth in the Insurance Policy/Evidence of Coverage. All claims for benefits will be processed and may be appealed in accordance with the procedures set forth in the Insurance Policy/Evidence of Coverage.

#### Deadline to Bring Legal Action

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the administrative process described in this section and as listed in your Insurance Policy/Evidence of Coverage. No action may be brought at all unless brought no later than one year following a final decision on your claim for benefits, unless a shorter period is provided in your Insurance Policy/Evidence of Coverage (in which case that time period controls). This statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

## **Article 6**

### **Other Legal Information**

#### Coordination of Benefits

Please see the applicable Insurance Policy/Evidence of Coverage for the rules on how the Plan will coordinate benefits with any medical plan that covers you or your Eligible Dependents.

#### Right of Recovery/Subrogation

Please see the applicable Insurance Policy/Evidence of Coverage for the Plan's rules on reimbursement and subrogation.

#### Applicable Law

The Plan 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 Pennsylvania, without giving effect to its conflicts of laws provision. The Plan 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.

#### Plan Amendment & Termination

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents. Nothing in this document or other communication from the Employer or its delegee with respect



to the Plan shall be deemed to create or imply a continuing obligation by the Employer to provide or fund benefits to current employees or their dependents or survivors, or retired or terminated employees or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

### Merger or Consolidation

In the event of any dissolution, merger, consolidation, or reorganization of the Employer in which the Employer is not the survivor, the Plan shall terminate with respect to the Employer and its Eligible Employees unless the Plan is continued by the successor to the Employer and such successor agrees to be bound by the terms and conditions of the Plan.

### Assignment of Benefits

You may not transfer or assign any benefit or right under the Plan. Any such assignment shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Participant or Eligible Dependent, but only as a convenience to Participants and Eligible Dependents. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants and Eligible Dependents under any circumstances.

### Missing Persons

If the Plan Administrator or Insurer cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual’s last known address as shown by the records of the Plan, the amount payable to the individual is forfeited.

### Right to Recover Overpayment

Payments are made in accordance with the provisions of the applicable Insurance Policy/Evidence of Coverage. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or any Insurer) will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any Participant or Eligible Dependent. Failure to comply with this request will entitle the Plan to withhold benefits due a Participant or Eligible Dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan’s behalf if the Plan’s collection effort is not successful.

In addition, if the overpayment is made to a provider, the Plan (or any Insurer) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any Participant or Eligible Dependent in the

Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans insured or administered by the Insurer, the Insurer may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

## Article 7 Legal Notices

### Newborns' & Mothers' Health Protection Act

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

### Statement of ERISA Rights

If you are a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

#### Receive Information About the Plan

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including, if applicable, insurance contracts, collective bargaining agreements, and a copy of the latest annual report 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, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

#### Prudent Actions by Plan Fiduciaries

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



other Plan Participants and Beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have appealed all adverse determinations you may file suit in a state or Federal court. Any such suit must be brought no later than 180 days following a final decision on the claim for benefits. If it should happen that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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.

### 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 Retiree Medical and Life Insurance 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

### **Insurer**

Highmark  
Freedom Blue PPO  
P.O. Box 1068  
Pittsburgh, PA 15230-1068  
1-800-550-8722  
[www.highmarkblueshield.com/medicare](http://www.highmarkblueshield.com/medicare)

## Appendix A

### Benefits under the Plan & Contact Information

This Summary Plan Description (SPD) should be read in connection with the applicable Insurance Policy/Evidence of Coverage provided by the Insurer listed below.

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning claims and appeals or the amount of benefits payable under the Plan, please refer to the Insurer listed below.

Medical and Prescription Drug Benefits	
Highmark Freedom Blue PPO	<ul style="list-style-type: none"><li>Fully insured</li><li>Covered by ERISA</li><li>Group Number: 178424</li><li>For details, see Insurance Policy/Evidence of Coverage: 2017 Evidence of Coverage for Freedom Blue PPO</li><li>Insurer: Highmark Freedom Blue PPO P.O. Box 1068 Pittsburgh, PA 15230-1068 1-800-550-8722 <a href="http://www.highmarkblueshield.com/medicare">www.highmarkblueshield.com/medicare</a></li></ul>



## Appendix B

The following Affiliates have adopted the Plan:

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