Quality health plans & benefits
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Welcome to Aetna **Health Reimbursement Arrangement (HRA) Plan Guide for 2017**

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New for 2017: Applied Behavior Analysis (ABA)

Starting in 2017, if your child has been diagnosed with an autism spectrum disorder, he or she will be eligible for ABA services. You can call Aetna at **1-877-512-0363** for details and requirements.

A Partnership For Your Care

Your health care is a responsibility shared by you, Aetna and your Company. All three play a role in helping you and your family make more informed decisions about your health care.

- Your Company provides you with a health care plan with 100% coverage for eligible in-network preventive care and a Health Reimbursement Arrangement (HRA) fund that pays a portion of your Annual Deductible.
- Aetna offers a network of physicians, hospitals and other health care providers and facilities that have undergone a strict credentialing process.
- Both Aetna and your Company provide self-help tools and resources to help you actively manage your health.
- Your responsibility is to get to know your Plan, use the resources that are available to you and make informed health care decisions to optimize your health.

This guide will help you make the most of your HRA Plan benefits and resources from Aetna.

How the HRA Plan Works

The HRA Plan has Four Main Parts

1 Annual Deductible

This is the amount of eligible medical expenses you must pay each Plan Year before the Plan begins to pay a percentage of those expenses.

2 HRA Fund

This is a fund established by your Company to help pay your Annual Deductible. At the beginning of each Plan Year (or as of your effective date of coverage, if later), your Company allocates a dollar amount to your HRA fund. All eligible medical expenses will be paid from your HRA fund first, except eligible in-network preventive care (which is covered at 100%) and prescription drug expenses, which do not apply to the Annual Deductible and are not paid from the HRA fund. After your HRA fund is used up, you pay for your eligible medical expenses until you reach your Annual Deductible.

HRA Rollover

Any HRA fund amount that you don't use during the Plan Year "rolls over" to the next Plan Year's HRA fund, which can be used to pay your portion of eligible medical out-of-pocket costs as long as you remain enrolled in the HRA Plan.

If you did not use all of your 2016 HRA fund and you enroll in the HRA Plan for 2017, your 2016 rollover amount will be used to help meet your 2017 Annual Deductible and, if any remains, to help pay your coinsurance for eligible medical expenses. If a claim incurred in 2016 is not submitted or received until 2017, the claim will be paid using your 2016 HRA rollover amount. However, if a claim incurred in 2016 is submitted or received in 2017 after your 2016 HRA rollover is depleted, you will still need to meet your 2016 Annual Deductible (if any remains) and pay any applicable coinsurance up to the applicable Out-of-Pocket Maximum.

3 Coinsurance

After you meet the Annual Deductible, you and the Plan share the cost of eligible services. This cost sharing is called coinsurance. For eligible in-network services, the Plan pays 80% and you pay 20% of prenegotiated fees. For eligible out-of-network services, the Plan pays 70% and you pay 30% of the Recognized Charge (also known as the "Reasonable and Customary" or "R&C" charge). (You must pay any fees in excess of the Recognized Charge.)

4 Out-of-Pocket Maximums

Your eligible in-network and out-of-network medical and prescription drug expenses (excluding eligible in-network preventive care expenses) both count toward the Out-of-Pocket Maximums. When your eligible expenses reach your in-network Out-of-Pocket Maximum, the Plan pays 100% for eligible in-network expenses for the remainder of the Plan Year.

When your eligible expenses reach your out-of-network Out-of-Pocket Maximum, the Plan pays 100% for eligible out-of-network expenses for the remainder of the Plan Year (you must pay any fees in excess of the Recognized Charge).

Important Note: Aetna HealthFund® (AHF) is Aetna's name for your HRA fund; the two terms refer to the same fund.

HRA Plan At A Glance

HRA Fund and Annual Deductible			
Family Status Category	Annual Deductible	HRA Fund Provided by the Company	Amount of Annual Deductible You Pay From HRA Rollover or Your Own Monies Before You Start Paying Coinsurance
You Only	$750	$500	$250
You + Spouse/Partner	$1,125	$750	$375
You + Child(ren)	$1,125	$750	$375
You + Family	$1,500	$1,000	$500

Coinsurance		
	In-Network	Out-of-Network
After your Annual Deductible is met	Plan Pays 80% / You Pay 20%	Plan Pays 70% / You Pay 30%

Out-of-Pocket Maximum[1]				
Family Status Category	Employees with Regular Annual Salary[2] of More than $70,000		Employees with Regular Annual Salary[2] of $70,000 or Less	
	In-Network	Out-of-Network	In-Network	Out-of-Network
You Only	$5,000	$8,350	$4,000	$6,000
You + Spouse/Partner	$8,500	$14,200	$7,000	$10,500
You + Child(ren)	$8,500	$14,200	$7,000	$10,500
You + Family	$10,000	$16,700	$8,000	$12,000

Any combination of eligible medical expenses from one or more covered family members can satisfy the Annual Deductible and the Out-of-Pocket Maximums. Any combination of eligible prescription drug expenses from one or more covered family members can satisfy the annual Out-of-Pocket Maximums.

If you cover family members, each covered individual is only responsible for the You Only Out-of-Pocket Maximum amount. Once it is met, eligible expenses for that individual will be covered at 100% for the remainder of the Plan Year.

[1]Your eligible in-network and out-of-network expenses both count toward the Out-of-Pocket Maximums. When your eligible expenses reach the in-network Out-of-Pocket Maximum, the Plan pays 100% for eligible in-network expenses. When your eligible expenses reach the out-of-network Out-of-Pocket Maximum, the Plan pays 100% for all eligible expenses.

[2]Your "Regular Annual Salary" does not include overtime, bonuses or any other additional compensation. For non-management salespersons, Regular Annual Salary includes the previous year's paid commissions. For purposes of calculating annual salary eligibility, Regular Annual Salary will be frozen as of July 1 of the preceding Plan Year for the following calendar year.

Example of How the HRA Plan Works

If your eligible medical expenses for the 2017 Plan Year are more than the amount in your HRA fund and they exceed your Annual Deductible:

- Company-provided HRA funds are used first
- Then you pay until the Annual Deductible is reached
- After the Annual Deductible is reached, you pay 20% coinsurance for in-network services and 30% for out-of-network services

Eligible Medical Expenses for 2017		**$10,000**
1	HRA fund pays ($1,000 contributed by the Company)	$1,000
2	You pay until the Annual Deductible is reached	$500
$1,500 Annual Deductible (reached)		
3	Remaining eligible expenses	$8,500
	You pay 20% coinsurance	$1,700
	Plan pays 80%	$6,800
You pay $2,200 and the Plan pays $7,800		

Status: You + Family

Annual Salary: Over $70,000

Annual Deductible: $1,500

Medical Expenses: All in-network

If you are enrolled in HealthAccount, amounts paid from your own monies can be reimbursed (see page 6).

Important Note: If you have any HRA rollover or have earned any incentives from 2016, they will be used to pay your Annual Deductible or your share of coinsurance before you pay from your own monies.

How to Pay for Medical Services

How the Process Works — In-Network Medical Claims

1 Present your HRA Plan ID card (called Choice POS II AHF) to the provider at the time of the visit.

2 Your provider may ask you to pay your portion of your Annual Deductible at the time of the visit. Please contact Member Services at the number on your ID card for assistance. Your provider will send your claim directly to Aetna.

3 Aetna will process your claim and you will be able to review claim activity on the Explanation of Benefits (EOB) statement on Aetna Navigator®, your secure member website. The EOB will indicate whether your Plan covered the services received and if so, what part of the covered services your Plan paid. See pages 11-12 for information about EOBs.

a. Covered expenses (except eligible in-network preventive care and prescription drug expenses) are applied to your Annual Deductible and paid from your HRA fund until the fund is exhausted. You are responsible for the difference between your HRA fund and your Annual Deductible. If you have any HRA rollover, including incentives earned in 2016, they will be used to satisfy your Annual Deductible before you use your own monies.

b. After you have met your Annual Deductible, you are responsible for the 20% coinsurance up to the in-network Out-of-Pocket Maximum. If you have any HRA rollover, including incentives earned in 2016, they will be used to pay the 20% coinsurance before you use your own monies.

c. Your provider will send you a bill for any remaining Annual Deductible and coinsurance you owe. If the expense is not eligible for payment under the HRA Plan, your provider will send you a bill.

4 If you receive a bill from your provider, before you pay the bill, make sure the claim has been sent to Aetna and the amount you owe is accurate. You can do this by:

- Checking your HRA fund and Annual Deductible activity by logging on to Aetna Navigator at **www.aetna.com**
- Checking the EOB
- Calling Member Services to check the status of your claim

If you are enrolled in HealthAccount and member responsibility remains for your Annual Deductible and/or your coinsurance — and your HRA fund (including rollover and incentives earned in 2016) has been used up — Aetna will automatically forward any remaining member liability to HealthAccount. You will receive reimbursement for that amount from HealthAccount as long as HealthAccount funds are available and expenses are eligible for reimbursement.

Special Note to Medicare-Eligible Members

You or your doctor will need to submit your covered medical expenses to Medicare first. Once Medicare processes your claim, it will automatically be forwarded to Aetna for consideration. Aetna will then process your claim on a secondary basis to Medicare.

If you or a covered dependent are eligible for Medicare but haven't enrolled for both Medicare Part A and Part B, enrollment should be initiated immediately by calling Social Security at **1-800-772-1213**. Otherwise, the Medicare-eligible individual's coverage in the HRA Plan will be secondary to Medicare Part A and Part B regardless of whether the individual has enrolled in Medicare Part A and B, resulting in higher out-of-pocket costs for the individual.

How the Process Works — Out-of-Network Medical Claims

1 Present your HRA Plan ID card (called Choice POS II AHF) to the provider at the time of the visit.

2 Your provider may collect payment from you at the time of the visit.

3 Obtain an Aetna Health Insurance claim form from the For Your Benefit website, where you can access Your Benefits Resources™ (YBR), at **www.resources.hewitt.com/jnjbsc** (this address is case sensitive, so use lower-case letters). You can also obtain the claim form by logging on to Aetna Navigator at **www.aetna.com** or by calling Member Services. After completing the claim form and attaching the bill or statement from your provider, mail it to the address specified on the back of your ID card.

Please note that if you have already paid your provider for the services rendered, sign box 12 only on the claim form to ensure that payment is mailed directly to you and not to your provider.

4 Aetna will process your claim. Reimbursement will be based on your out-of-network benefit and the Recognized Charge. (You must pay any amount in excess of the Recognized Charge.) You will be able to review claim activity on the Explanation of Benefits (EOB) statement on Aetna Navigator. The EOB will indicate whether your Plan covered the services received and if so, what part of the covered services your Plan paid. See pages 11-12 for information about EOBs.

a. The covered expenses (except prescription drug expenses) will be applied to your Annual Deductible and paid from your HRA fund until the fund is exhausted. You are responsible for the difference between your HRA fund and your Annual Deductible. If you have any HRA rollover, including incentives earned in 2016, they will be used to satisfy your Annual Deductible before you use your own monies.

b. After you have met your Annual Deductible, you are responsible for the 30% coinsurance up to the out-of-network Out-of-Pocket Maximum. If you have any HRA rollover, including incentives earned in 2016, they will be used to pay the 30% coinsurance before you use your own monies.

c. Your provider will send you a bill for any remaining Annual Deductible and coinsurance you owe. If the expense is not eligible for payment under the HRA Plan, your provider will send you a bill.

If you are enrolled in HealthAccount and member responsibility remains for your Annual Deductible and/or your coinsurance — and your HRA fund (including rollover or incentives earned in 2016) has been used up — Aetna will automatically forward any remaining member liability (including any amount over the Recognized Charge) to HealthAccount. You will receive reimbursement for that amount from HealthAccount as long as HealthAccount funds are available and expenses are eligible for reimbursement.

Important Information on Certain Non-Participating Providers

When a non-participating provider offers to accept the Plan's payment as full payment for a service while waiving any amount (Annual Deductible or coinsurance) normally owed by the patient, this is considered Fee Forgiving. When Aetna is aware of a Fee Forgiving situation, the Plan will not cover any amount not billed to the patient because it has been forgiven. See your Summary Plan Description for more detail.

Special Note to Medicare-Eligible Members

You or your doctor will need to submit your covered medical expenses to Medicare first. Once Medicare processes your claim, it will automatically be forwarded to Aetna for consideration. Aetna will then process your claim on a secondary basis to Medicare.

If you or a covered dependent are eligible for Medicare but haven't enrolled for both Medicare Part A and Part B, enrollment should be initiated immediately by calling Social Security at **1-800-772-1213**. Otherwise, the Medicare-eligible individual's coverage in the HRA Plan will be secondary to Medicare Part A and Part B regardless of whether the individual has enrolled in Medicare Part A and B, resulting in higher out-of-pocket costs for the individual.

Save Money by Staying in the Network

When you use Aetna network doctors and facilities, the amount you pay for services is generally reduced, often by a lot. We negotiate lower fees with these providers. They are not allowed to charge you more. And the percentage of the negotiated fee you need to pay — your coinsurance percentage — is also lower.

Out-of-network care

If you choose to go outside the network, the amount you pay may increase three different ways:

1) There is no discounted fee arrangement. Plan reimbursements are based on the Recognized Charge* (also known as the "Reasonable and Customary charge," or "R&C charge"), which is often higher.
2) Your coinsurance percentage — the amount of the Recognized Charge that you need to pay — is higher.
3) You may have to pay the full amount of a provider's charges that exceed the Recognized Charge.

Recognized Charge for out-of-network doctors and other professionals

The Recognized Charge is a fee that is determined to be consistent with that of doctors, hospitals or other health providers for a given procedure in a given geographical area. If you go outside the network, we will conduct a detailed review of your claim and compare it to industry data to determine the Recognized Charge and how much you will need to pay.

To determine Recognized Charges for professionals, we first get information from FAIR Health, Inc. FAIR Health gathers data about health claims across the country and combines this information in databases that show doctor charges for just about any service in any ZIP code.

Then we calculate the portion the plan will pay. The 90th percentile is used to calculate how much to pay for out-of-network services.

Payment at the 90th percentile means 90 percent of charges in the database are the same or less for that service in a particular ZIP code.

Sometimes what the plan pays is less than what your doctor charges. In that case, your doctor may require you to pay the difference.

We may consider other factors to determine what to pay if a service is unusual or not performed often in the doctor's area.

These factors can include the:

- Complexity of the service
- Degree of skill needed
- Doctor's specialty
- Prevailing charge in other areas

Recognized Charge for out-of-network hospitals and facilities

For care provided by hospitals and other facilities, we review the services provided to determine the Recognized Charge for the service. We do this by comparing the services provided to generally accepted standards of medical practice, cost report information provided to government agencies and data submitted by commercial insurance carriers to external agencies for the relevant geographical area.

Payment is based on the Recognized Charge, which may be less than the charge submitted by the provider. As part of this process, Aetna will request that the provider accept the Recognized Charge. If you do receive a bill from the provider for an amount above the Recognized Charge, please contact Member Services at **1-877-512-0363**. Since Aetna cannot guarantee a reduction in charges, you may be responsible for paying the remaining balance.

*Reflects the current administrative procedures for determining the Recognized Charge. Those procedures, as well as the terms of the plan, may change from time to time.

Prescription Drug Coverage

Know What the Plan Will Pay — With Pre-Determination of Medical Benefits

It can be helpful to know whether or not the Plan will cover a service, supply or treatment, and how benefits will be paid before you incur the expense. You can find out by requesting a pre-determination of medical benefits. You may want to do this for care such as:

- Inpatient or outpatient surgery
- Maternity
- Durable medical equipment (wheelchair, for example)
- Speech, occupational or physical therapy

To request a pre-determination of medical benefits, you'll need to complete the enclosed form. You can also download a copy from Aetna Navigator. Log on to **www.aetna.com** and look for the View Important Additional Information link on your home page.

Instructions and a mailing address are included on the form. It takes about ten working days for Aetna to process your request. To determine how benefits will be paid, Aetna will take into consideration whether the care is medically necessary, whether the charge for it is the Recognized Charge, and whether your doctor is an approved provider for the care. Aetna will send its pre-determination of medical benefits to you, in writing, via regular mail.

Special Note to Medicare-Eligible Members

Medicare will make the determination of medical necessity. There would not be a need to submit a pre-determination of benefits to Aetna.

Adding a Dependent to Your Coverage

During the year, you may experience a qualified status change, such as getting married or having a baby, which allows you to enroll your new dependent(s). If this happens and you want to enroll your new dependent(s), you must do so through the For Your Benefit website, where you can access YBR, at **www.resources.hewitt.com/jnjbsc** within 60 days after the qualified status change. You must also provide appropriate documentation verifying eligibility of the dependent(s) to the Benefit Service Center. More information about this is available on YBR.

Prescription drug benefits are administered by Express Scripts®.

If you are new to the Plan, Express Scripts will provide you with a Welcome Package that will explain in greater detail the services that are offered by Express Scripts. Express Scripts prescription drug ID cards will also be included in that mailing.

The Express Scripts Member Services number is **1-866-713-7779**. Representatives are available 24 hours a day, 7 days a week, except Thanksgiving and Christmas days.

As a reminder, expenses for prescription drugs do not count toward the Annual Deductible, nor can they be paid for from the HRA fund.

You will not have a separate prescription drug Out-of Pocket Maximum; both your medical and prescription drug expenses will count toward the annual Out-of-Pocket Maximums. Once the annual Out-of-Pocket Maximum is reached, eligible prescription drugs will be covered at 100% for the remainder of the Plan Year. See page 4 for more information.

If you already have Express Scripts as your prescription drug service administrator, please continue to use your existing Express Scripts prescription drug ID card when you are purchasing drugs at your local pharmacy. The network of pharmacies remains the same and home delivery services remain with Express Scripts.

If you are new to Express Scripts, you will receive a separate prescription drug ID card from them after your enrollment is processed.

You can view details of your retail and home delivery pharmacy claims at **www.express-scripts.com/jnj**. This website will also contain information on the amounts applied to your annual Out-of-Pocket Maximums.

Tip: Take advantage of drug manufacturer discount coupons. You will save money at your local pharmacy as your out-of-pocket cost will be the lower amount, but the full retail price will be credited toward your annual Out-of-Pocket Maximums.

ID Cards

Your ID card is your passport to access the HRA Plan, so it's important that you present your ID card whenever each covered family member receives care.

Your ID card contains useful information such as the toll-free dedicated Member Services phone number, the address for submitting claims and that eligible in-network preventive services are paid at 100%.

If you were not enrolled in the HRA Plan administered by Aetna in 2016 but are enrolling in it for 2017, or if you are changing who is covered for 2017, or if your salary tier changes (see chart on page 4), a family ID card listing each covered person will arrive in the mail after you enroll. Please check the card to make certain all the information is correct.

If you find an error, contact Member Services at **1-877-512-0363** for assistance. Representatives are available Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern Time.

For a temporary ID card or to order replacement cards, you may log on to Aetna Navigator at **www.aetna.com*** and from the I want to box:

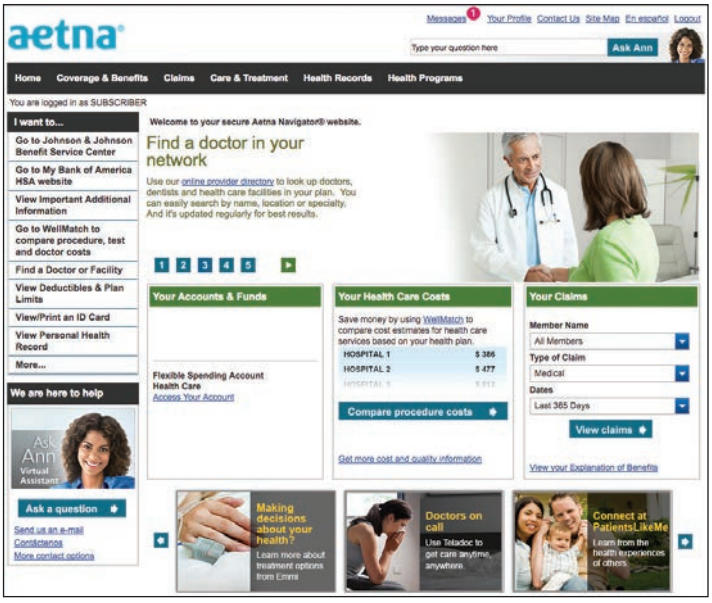
1. Click on View/Print an ID Card.
2. Choose who the card is for.
3. Click on View Card, then choose to View/Print ID Card or Order a Replacement Card.

*If you have not already done so, you must register for Aetna Navigator in order to access this and other information. See page 16 for instructions on how to register.

How to Track Your Costs and Claims

You can easily track costs and claims for you and your covered dependents by reviewing the EOB statements (including the Monthly Summary Statements) that are available on Aetna Navigator at **www.aetna.com** under the Claims tab.

You may check your HRA fund and HealthAccount balances at any time through Aetna Navigator by clicking on the Home tab and then on the applicable link in the Your Accounts & Funds box. If you were enrolled with Aetna in 2016, any 2016 HRA fund rollover (up to the amount of the in-network medical Out-of-Pocket Maximum) will be posted on January 2, 2017. Under Your Accounts & Funds, click on Details; any earned incentives from 2016 will be posted under the Contributions tab. (See the Your Personalized Health Plan Website section on page 16 to learn more about Aetna Navigator.)



Retirement HRA

If the balance in your 2016 HRA fund exceeds your 2016 in-network medical Out-of-Pocket Maximum, the excess amount will be placed in a Retiree Reimbursement Account (RRA) after April 1, 2017.

This RRA will be a dormant account held by UnitedHealthcare and will become available if you retire from Johnson & Johnson, meet the Retiree Medical Plan's eligibility criteria and elect Retiree Medical coverage in one of certain options.

To locate any applicable RRA balances after April 1, 2017, visit the UnitedHealthcare website at **www.uhcretireeaccounts.com** or call Member Services at **1-866-868-0511**, Monday through Friday from 8:00 a.m. to 8:00 p.m. local time.

EOB Statements

An Explanation of Benefits (EOB) statement shows the details of claims that have been processed. EOB statements are generated and are available online through Aetna Navigator* (under the Claims tab) as follows:

After every medical claim is processed (including if your claim is denied, on hold awaiting additional information or if a payment is due to you or a provider), the EOB will show:

- The individual claim details, including what the Plan pays and your responsibility.
- Year-to-date details of claim payments (except for pharmacy claims), including amounts paid from your HRA fund, coinsurance payments and how much has been applied to your Out-of-Pocket Maximum totals. You can check how much has been applied to your Annual Deductible and Out-of-Pocket Maximums, including prescription drug claims, through Aetna Navigator by clicking on the Home tab and then on View Deductibles & Plan Limits.

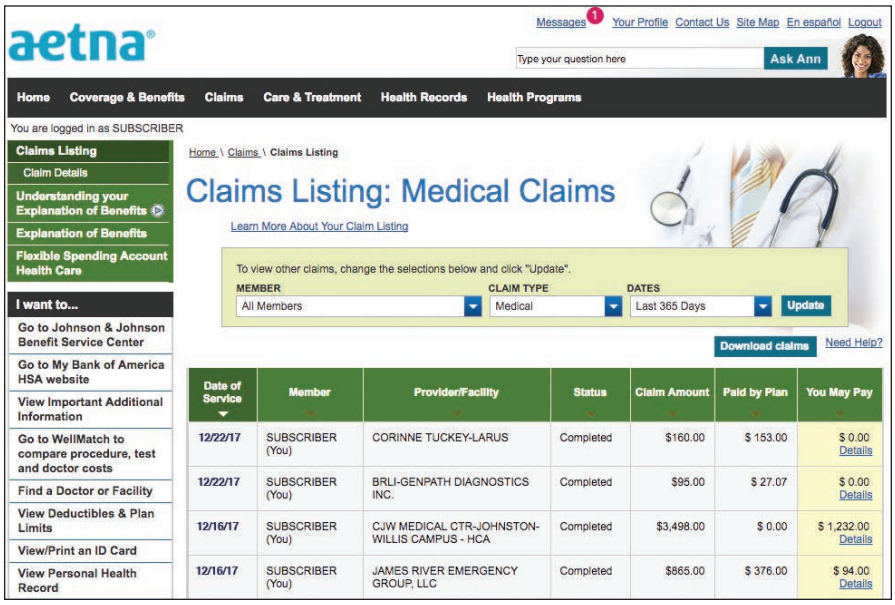
A Monthly Summary Statement that details Plan activity for all covered family members is generated if you have had claim activity during the previous month. This statement will provide information regarding claims paid (except for pharmacy claims), your available HRA fund balance and any amounts you owe to providers or have already paid (see page 12 for more details).

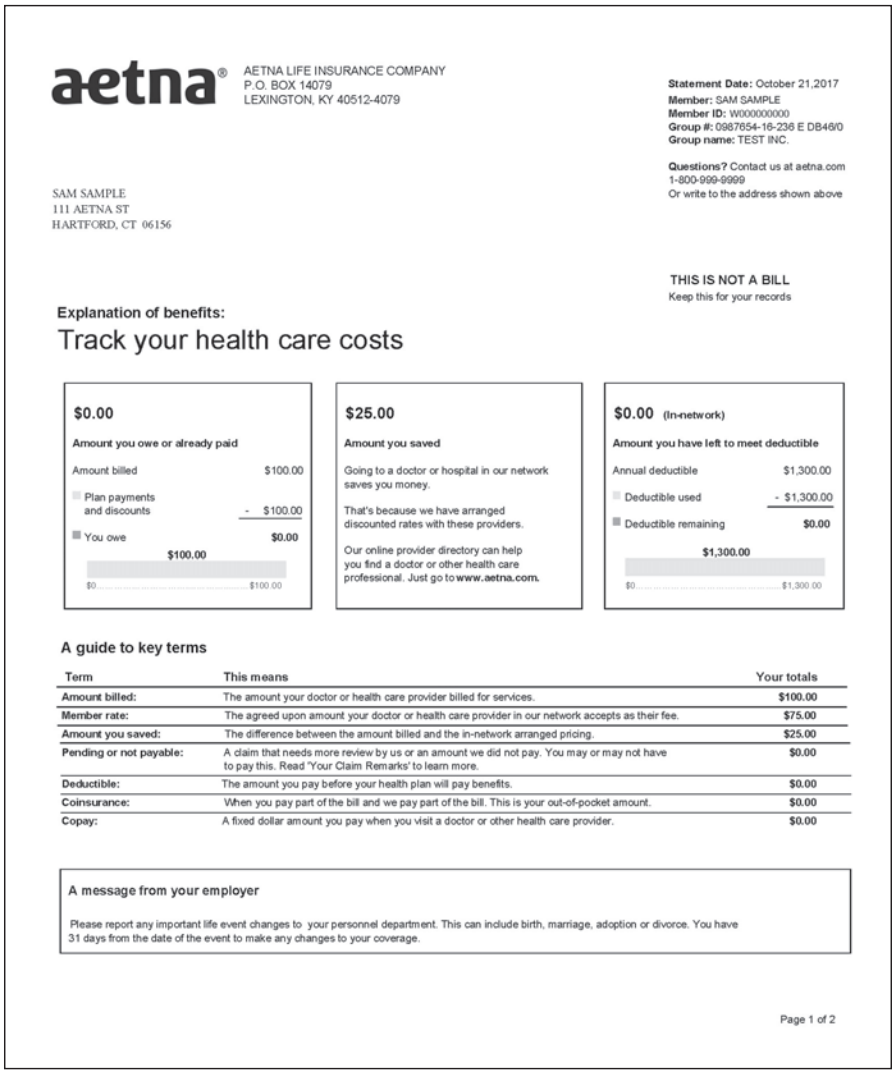
For details on prescription drug claims, go to **www.express-scripts.com/jnj**.

*If you want to receive paper EOBs, you will need to change the default option on Aetna Navigator. Look under My Profile at the top of the page, then click on Paper Saving Preferences to make the change.

Turn Off Paper — Default Option

When you register for Aetna Navigator, "Turn Off Paper" is automatically set and you can view all your EOBs online and not receive any through the mail. You can receive e-mail notification when new EOBs are available if you have registered as an Aetna Navigator user.

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AETNA LIFE INSURANCE COMPANY
P.O. BOX 14079
LEXINGTON, KY 40512-4079

Statement Date: October 21,2017
Member: SAM SAMPLE
Member ID: W000000000
Group #: 0987654-16-236 E DB46/0
Group name: TEST INC.

Questions? Contact us at aetna.com
1-800-999-9999
Or write to the address shown above

SAM SAMPLE
111 AETNA ST
HARTFORD, CT 06156

THIS IS NOT A BILL
Keep this for your records

Explanation of benefits:

Track your health care costs

$0.00
Amount you owe or already paid
Amount billed $100.00
Plan payments and discounts - $100.00
You owe $0.00
$100.00
$0 $100.00

$25.00
Amount you saved
Going to a doctor or hospital in our network saves you money.
That's because we have arranged discounted rates with these providers.
Our online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

$0.00 (In-network)
Amount you have left to meet deductible
Annual deductible $1,300.00
Deductible used - $1,300.00
Deductible remaining $0.00
$1,300.00
$0 $1,300.00

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your doctor or health care provider billed for services.	$100.00
Member rate:	The agreed upon amount your doctor or health care provider in our network accepts as their fee.	$75.00
Amount you saved:	The difference between the amount billed and the in-network arranged pricing.	$25.00
Pending or not payable:	A claim that needs more review by us or an amount we did not pay. You may or may not have to pay this. Read 'Your Claim Remarks' to learn more.	$0.00
Deductible:	The amount you pay before your health plan will pay benefits.	$0.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is your out-of-pocket amount.	$0.00
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	$0.00

A message from your employer

Please report any important life event changes to your personnel department. This can include birth, marriage, adoption or divorce. You have 31 days from the date of the event to make any changes to your coverage.

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Understanding Your EOB Monthly Summary Statement

1. **Mailing address.** Member name and mailing address.
2. **Contact information.** The member ID used on the ID card (you'll need this number when you contact Member Services) and contact information for any questions.
3. **Summary of Claims Reviewed and Benefit Year.** The month during which your claims were processed by Aetna and the Plan Year in which the claims were incurred.
4. **Charges from Health Care Professionals.** The amount billed for the service(s). This is the amount the provider charged and may not reflect any prenegotiated discounts for in-network providers or the application of the Recognized Charge if the health care professional is an out-of-network provider. Claim detail on subsequent pages illustrates the prenegotiated and/or Recognized Charge.
5. **Under Review/Not Paid.** The amount of the claim(s) being reviewed or denied by Aetna.
6. **Payments Made.** The amount Aetna paid, which could be paid from your HRA fund or from Aetna's coinsurance portion.
7. **You Pay Out of Pocket.** The amount you must pay the provider(s). This could include any portion of the fee not covered by the Plan, the amount you pay toward your Annual Deductible and/or your coinsurance portion. Your provider(s) will bill you for this amount, or you may have already paid it if you used an out-of-network provider.
8. **Your YTD Account Balances — Your HRA Fund.**

   Annual Starting Amount – the amount your Company contributed to your HRA fund at the beginning of the Plan Year (or as of your effective date of coverage, if later), plus any rollover and earned incentives from 2016.

   Spent Year-to-Date – the amount Aetna deducted from your HRA fund to pay your and your covered family members' eligible medical expenses during the current Plan Year.

   Amount Remaining – your remaining HRA fund for the current Plan Year.

9. **Your YTD Account Balances — Your Deductible.**

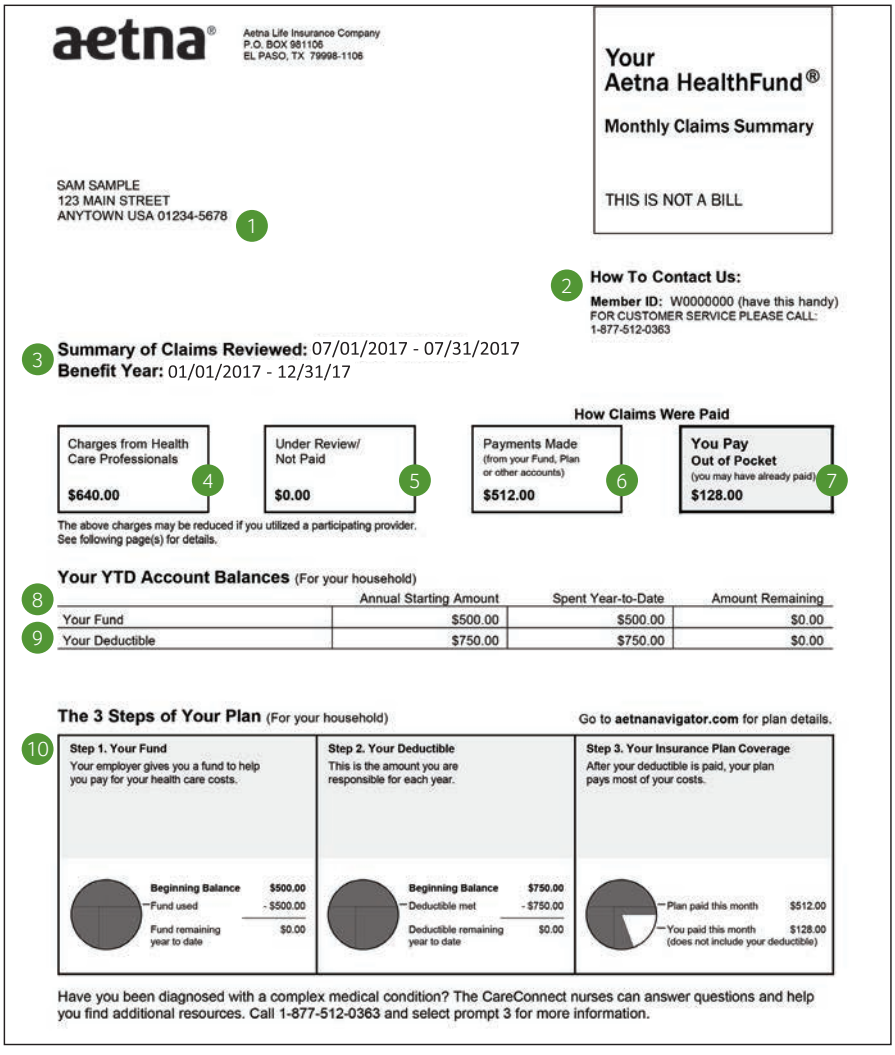
   Annual Starting Amount – your Annual Deductible amount.

   Spent Year-to-Date – the amount paid toward your Annual Deductible for your and your covered family members' eligible medical expenses during the current Plan Year.

   Amount Remaining – the amount left to pay toward your Annual Deductible for the Plan Year.

10. **The 3 Steps of Your Plan.** A graphic representation of your HRA fund and deductible amount shown above as well as the payments made during the month covered by this EOB statement.

Important Note: Aetna HealthFund is Aetna's name for your HRA fund; the two terms refer to the same fund.


aetna®

Aetna Life Insurance Company
P.O. BOX 981106
EL PASO, TX 79998-1106

Your Aetna HealthFund®

Monthly Claims Summary

THIS IS NOT A BILL

SAM SAMPLE
123 MAIN STREET
ANYTOWN USA 01234-5678 1

2 How To Contact Us:
Member ID: W0000000 (have this handy)
FOR CUSTOMER SERVICE PLEASE CALL:
1-877-512-0363

3 Summary of Claims Reviewed: 07/01/2017 - 07/31/2017
Benefit Year: 01/01/2017 - 12/31/17

How Claims Were Paid

Charges from Health Care Professionals 4	Under Review/ Not Paid 5	Payments Made (from your Fund, Plan or other accounts) 6	You Pay Out of Pocket (you may have already paid) 7
$640.00	$0.00	$512.00	$128.00

The above charges may be reduced if you utilized a participating provider. See following page(s) for details.

Your YTD Account Balances (For your household)

	Annual Starting Amount	Spent Year-to-Date	Amount Remaining
8 Your Fund	$500.00	$500.00	$0.00
9 Your Deductible	$750.00	$750.00	$0.00

The 3 Steps of Your Plan (For your household) Go to aetnanavigator.com for plan details. 10

Step 1. Your Fund
Your employer gives you a fund to help you pay for your health care costs.
Beginning Balance $500.00
Fund used - $500.00
Fund remaining year to date $0.00

Step 2. Your Deductible
This is the amount you are responsible for each year.
Beginning Balance $750.00
Deductible met - $750.00
Deductible remaining year to date $0.00

Step 3. Your Insurance Plan Coverage
After your deductible is paid, your plan pays most of your costs.
Plan paid this month $512.00
You paid this month (does not include your deductible) $128.00

Have you been diagnosed with a complex medical condition? The CareConnect nurses can answer questions and help you find additional resources. Call 1-877-512-0363 and select prompt 3 for more information.

Preventive Care

Preventive care is defined as periodic well visits, routine immunizations and routine screenings provided to you when you have no symptoms or have not been diagnosed with a disease or medical condition. Additional immunizations and screenings may be included for those individuals at increased risk (for example, a family history) for a particular disease or medical condition.

The **HRA Plan covers eligible preventive care at 100%** when you receive it from an in-network provider. That means:

- No cost to you
- No Annual Deductible to meet
- It is not paid from your HRA fund

It is important that your provider submit these services as preventive care. When speaking with your provider, be sure to mention that these services must be coded properly as preventive in order to be covered at 100% in-network. This also includes lab or diagnostic tests associated with the preventive care visits if they are not performed by your provider or in your provider's office.

If you use an **out-of-network provider**, you must first meet the Annual Deductible and then pay 30% coinsurance, subject to the Recognized Charge, just as you would for any other eligible out-of-network expense.

A list of the medical services that are considered preventive care under the Plan can be found on the For Your Benefit website, where you can access YBR, at **www.resources.hewitt.com/jnjbsc**. These preventive services include but are not limited to the U.S. Preventive Services Task Force (USPSTF) recommendations. The HRA Plan is in compliance with the USPSTF recommendations as required by Health Care Reform [Patient Protection and Affordable Care Act (PPACA)] and the Women's Preventive Services Guidelines.

Those with high risk or family history are encouraged to speak with their health care provider about the guidelines to determine what services are considered appropriate preventive care.

New Healthy & Me™ wellness incentives are coming in 2017! Stay tuned for more information.

CareConnect

What Is CareConnect?

CareConnect is a free, voluntary and confidential program offered directly through your HRA Plan. CareConnect gives you direct access to experienced professionals with a broad range of knowledge and understanding of specific health care issues and situations. The program helps you manage acute and complex medical conditions and provides program resources to you if you have questions about a chronic condition.

About the CareConnect Team

The CareConnect team includes Registered Nurses (generalists as well as oncology and transplant experts) and other health care professionals, all of whom are working in conjunction with a Medical Director. The program's primary nurse approach is designed to ensure that the same nurse will work with you and your covered family members over multiple care episodes when possible.

If a covered family member is facing the advanced stages of a terminal illness and you want help finding the right resources for him or her, the Aetna Compassionate Care℠ program offers service and support. Log on to Aetna Navigator at **www.aetna.com** and click on Dealing with advanced illness under the Care & Treatment tab for information about such things as making a living will, durable power of attorney and finding hospice care.

How CareConnect Works

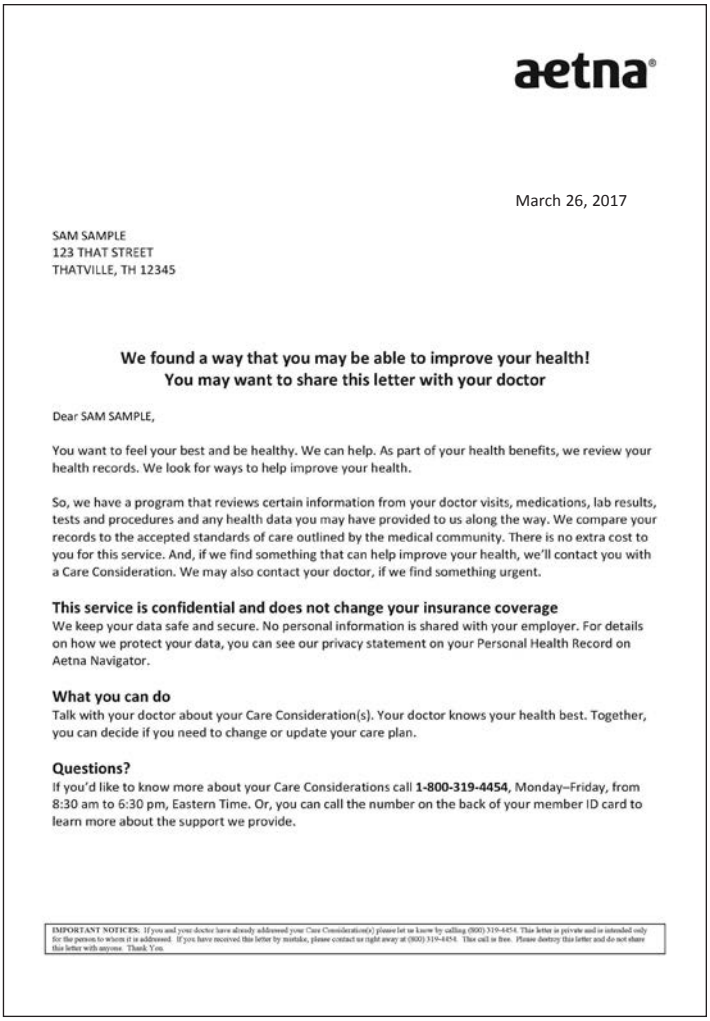
You may be contacted by phone by a CareConnect Registered Nurse or other CareConnect health care professional or receive a letter from the CareConnect team if health care claims data show that for you or a covered dependent:

- Claims have been received for a particular condition, such as cancer, a serious injury or an organ transplant.
- Aetna has been contacted for pre-admission approval of an upcoming inpatient hospitalization or a hospitalization has occurred.

Additionally, CareConnect will send you a letter when they notice an opportunity to ensure that you or a covered dependent is receiving care appropriate for your age, gender or health status, such as lab tests that should be performed on a regular basis for a specific condition or preventive care screening tests. A letter is also sent to your doctor, and the message appears on your Personal Health Record (PHR) (see page 20 for more information).

Preventive care reminders will be sent to you via your PHR.

Letters will be sent to you from Aetna. If you receive a letter (see the sample to the right) and/or message from Aetna, you should know that this is a service provided through the CareConnect program.



aetna®

March 26, 2017

SAM SAMPLE
123 THAT STREET
THATVILLE, TH 12345

We found a way that you may be able to improve your health!
You may want to share this letter with your doctor

Dear SAM SAMPLE,

You want to feel your best and be healthy. We can help. As part of your health benefits, we review your health records. We look for ways to help improve your health.

So, we have a program that reviews certain information from your doctor visits, medications, lab results, tests and procedures and any health data you may have provided to us along the way. We compare your records to the accepted standards of care outlined by the medical community. There is no extra cost to you for this service. And, if we find something that can help improve your health, we'll contact you with a Care Consideration. We may also contact your doctor, if we find something urgent.

This service is confidential and does not change your insurance coverage
We keep your data safe and secure. No personal information is shared with your employer. For details on how we protect your data, you can see our privacy statement on your Personal Health Record on Aetna Navigator.

What you can do
Talk with your doctor about your Care Consideration(s). Your doctor knows your health best. Together, you can decide if you need to change or update your care plan.

Questions?
If you'd like to know more about your Care Considerations call **1-800-319-4454**, Monday–Friday, from 8:30 am to 6:30 pm, Eastern Time. Or, you can call the number on the back of your member ID card to learn more about the support we provide.

IMPORTANT NOTICES: If you and your doctor have already addressed your Care Consideration(s) please let us know by calling (800) 319-4454. This letter is private and is intended only for the person to whom it is addressed. If you have received this letter by mistake, please contact us right away at (800) 319-4454. This call is free. Please destroy this letter and do not share this letter with anyone. Thank You.

Obtain Valuable Services by Contacting CareConnect Directly

You can contact CareConnect directly by calling Aetna toll free at **1-877-512-0363** any business day from 8:00 a.m. to 7:00 p.m. Eastern Time. Call when you have questions about your or a covered dependent's health (including a new diagnosis, suggested treatment, side effects, etc.), for example:

- If your son is scheduled for surgery and you want to review what he can expect during his admission and after discharge, making sure he is set for post-surgical care, including physical therapy and any home health care he might need.
- If your spouse had a heart attack and you and he (with his approval) want his medical information reviewed in order to discuss his health status, what may have led to the heart attack and the steps for recovery that he might discuss with his physician, including recommended medications (with possible side effects) and activities to help regain mobility.
- If you were recently diagnosed with prostate cancer and want to discuss the diagnosis with a CareConnect nurse who can provide suggestions about the most appropriate treatment, including what is covered under your Plan, and talk with your doctor (if you provide permission) to help coordinate your care.

For more information on the CareConnect program, call **1-877-512-0363** any business day from 8:00 a.m. to 7:00 p.m. Eastern Time or view the CareConnect brochure by logging on to Aetna Navigator at **www.aetna.com** or the For Your Benefit website, where you can access YBR, at **www.resources.hewitt.com/jnjbsc.**

A Commitment to Your Privacy

Aetna is committed to protecting your privacy. Your personal health information will be kept strictly confidential in accordance with appropriate privacy policies and applicable law, including relevant provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any contact you have with CareConnect will be kept strictly confidential. No one at your Company will have access to your personal CareConnect counseling information without your prior written consent.

Remember, there is no cost to you for participating in CareConnect.

CareConnect is intended to supplement the patient-doctor relationship — not replace it. You should consult with your doctor before making any final decisions.

Tools and Programs

As an Aetna member, you have access to a variety of convenient tools to help you make informed decisions about your care, find useful information and follow developments in medicine that can help you get and stay healthy. If you choose, you can also save money through special discount programs.

Your Personalized Health Plan Website

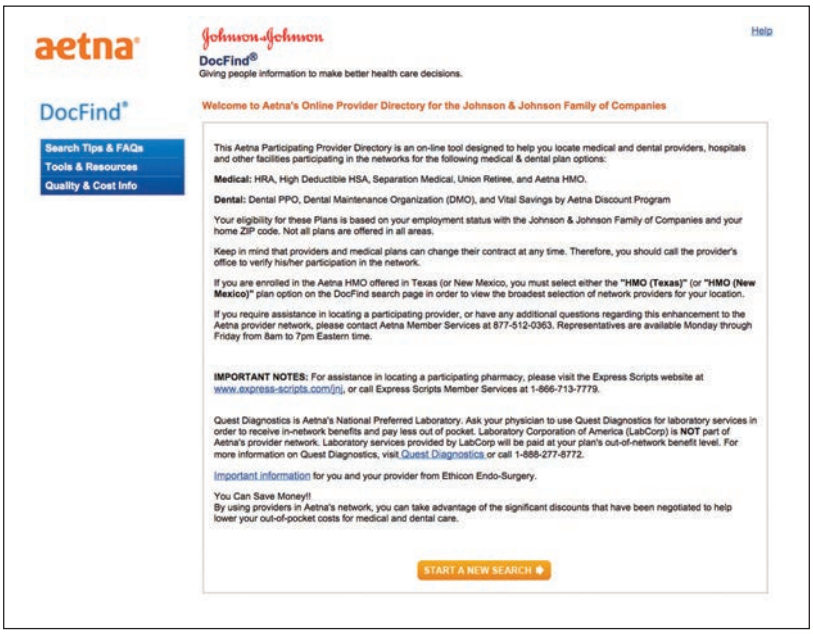
Aetna Navigator, at **www.aetna.com**, is your personalized member website. Your first step is to register and set up your user name and password:

1. **Click on the Log In/Register box, and select Login and then Register now.**
   Your spouse/partner and dependent children ages 18 or older can set up their own Navigator accounts. Dependents do not have access to all the features of Aetna Navigator, but they'll need to register to access their Personal Health Record.
2. **Provide the information requested.**
   You will need your Aetna member ID number (from your ID card) or your Social Security number.
3. **Choose a user name and password.**

When your registration is complete, you'll be able to use all the features of Aetna Navigator, such as:

Access your online provider directory

- **Use the Aetna DocFind®** online directory to find health care professionals and facilities that participate in the Plan. (You may access DocFind through Aetna Navigator or at **www.aetna.com/docfind/custom/jnj**.) When prompted to Select a Plan, you'll need to select the HRA Plan.



Manage your health care

- **Health history report** – Receive a personalized health report for you and each covered family member that organizes all your claims in one convenient place. Click on the Care & Treatment tab, then Print your Health History Report.
- **Claims information** – Find claims information and EOB statements under the Claims tab.
- **Account balances** – Find HRA fund and HealthAccount balances by clicking on the Home tab and then on the applicable Details under Your Accounts & Funds.

Take care of administrative tasks

- **ID cards** – Print wallet-size temporary member ID cards and order replacement member ID cards by clicking Get an ID Card from the left navigation bar.
- **Aetna Member Services** – Get phone numbers and mailing addresses and send secure e-mails. Click on Contact Us in the upper right corner of the screen.

Access online health information under Health Programs

- **Staying healthy** – Learn about health issues specific to men, women and children. Find information on specific preventive care and screening schedules by age and gender, as well as important health recommendations.
- **Healthwise® Knowledgebase** – Get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

Teladoc®

Teladoc is an additional service that helps you resolve many of your medical issues — anytime day or night — through the convenience of phone and online video consultations.*

With your consent, information from your Teladoc consultation can be sent to your primary care physician. Additionally, Teladoc is a convenient and affordable alternative to costly urgent care and ER visits for non-emergency medical care. You also save the time spent driving to and sitting in a waiting room.

New for 2017: Behavioral health support

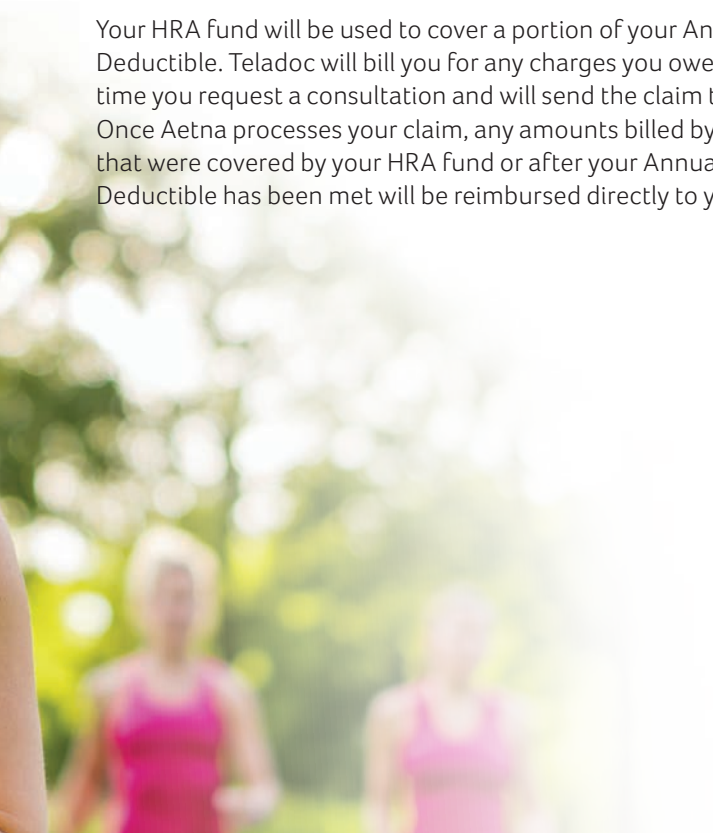
Teladoc's behavioral health professionals can help with addiction, depression, mental/physical challenges, family difficulties and other challenges. Whether you need one or multiple consultations, Teladoc can help you find peace of mind.

Your cost for a Teladoc consultation for a behavioral health issue (video consultation only) varies by the type of therapist:

- $160 for psychiatrist (initial visit)
- $90 for psychiatrist (ongoing visits)
- $80 for psychologist, licensed clinical social worker, counselor or therapist

All other Teladoc consultations are $40. Once you meet your Annual Deductible, all Teladoc consultations are covered at 100%.

Your HRA fund will be used to cover a portion of your Annual Deductible. Teladoc will bill you for any charges you owe at the time you request a consultation and will send the claim to Aetna. Once Aetna processes your claim, any amounts billed by Teladoc that were covered by your HRA fund or after your Annual Deductible has been met will be reimbursed directly to you.



With Teladoc you can:

- **Resolve many of your medical issues**
  Teladoc can diagnose many of your medical issues, as well as recommend treatment and prescribe medication, when appropriate.
- **Get quality care for conditions including**
  - Sinus problems
  - Bronchitis
  - Allergies
  - Poison ivy
  - Cold and flu symptoms
  - Urinary tract infection
  - Respiratory infection
  - Behavioral health issues
- **Speak with U.S. board-certified doctors**
  Teladoc's national network includes the highest quality, state licensed doctors who will call you back within 16 minutes, on average.
- **Use it anywhere/anytime**
  Teladoc doctors are available 24/7/365 via phone and online video consultations.
- **Save money**
  Teladoc costs less than an urgent care or ER visit, and never more than a doctor visit.

Use Teladoc when you:

- Need care now
- Are considering the ER
- Are on vacation

A Welcome Kit will be mailed to your home with instructions for getting started with Teladoc. Once you receive your Welcome Kit:

1. Follow the instructions in the Welcome Kit to set up your account.
2. Complete your medical history and set up eligible dependents.
3. Request a consultation online or by phone.

Teladoc can be reached 24 hours a day, 7 days a week, at **1-855-835-2362** or via **www.teladoc.com/aetna**.

*Teladoc operates subject to state regulation and may not be available in certain states.

New for 2017: Earn points with Teladoc

In 2017, you can earn points on the Healthy & Me app for viewing a short video on Teladoc and completing registration. Look for more information on the Healthy & Me app.

WellMatch®

WellMatch is an online tool that helps you get the most from your Aetna benefits.

Get the information you need

On the WellMatch website, you can make informed decisions about health care providers based on price, quality and convenience.

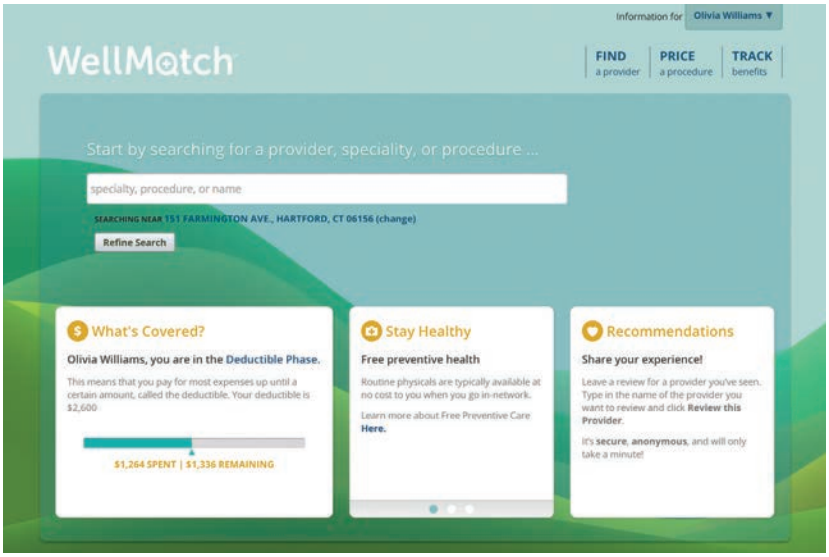
Search for providers close to where you live or work, and view side-by-side cost estimates for a specific procedure.

Personalized for you

WellMatch is populated with your current medical plan information.

You can track your out-of-pocket spending and get personalized cost estimates for common procedures at local in-network providers.

To use WellMatch, log on to Aetna Navigator at **www.aetna.com** and click on Go to WellMatch on the left.



Save on your lab work with in-network lab benefits.

There's an easy way to save on out-of-pocket costs, and it's one you might not even think about: getting lab work done in-network. Quest Diagnostics® is the only national in-network lab in your Aetna plan. (LabCorp is out of network.)

Quest Diagnostics offers you other advantages, including:

- Convenience: Visit Quest Diagnostics at **www.questdiagnostics.com** for online appointment scheduling.
- Lower prices: Lower your out-of-pocket costs and put the savings where they belong — in your pocket.
- Nearby locations: With thousands of locations nationwide, you can find one close to your job, home or doctor's office.

Aetna Healthy Lifestyle Coaching (HLC) Tobacco Free

HLC Tobacco Free is a voluntary tobacco cessation program that's offered to you and your covered dependents at no cost. You'll work with certified tobacco cessation wellness coaches to help you quit tobacco and achieve your health goals. To join, just call **1-866-213-0153** Monday through Friday 8:00 a.m. to 10:00 p.m. Eastern Time.

You can select the type of coaching you'd like:

- 30-minute one-to-one coaching sessions or
- Live online group coaching sessions

You can also receive eight weeks of Nicotine Replacement Therapy at no cost to you, to support you in your efforts to quit tobacco. Additional coverage of tobacco cessation medications is also available through your prescription drug plan. Please call Express Scripts at **1-866-713-7779** for more information on this.

Discounts to Help You Save

As an Aetna member, you are eligible for the following discounts at no additional cost:

At home products

Save on blood pressure monitors, apparel, toys, and financial and legal services.

Books

Pay less for books, CDs, DVDs, videos, family reading, magazine subscriptions and gifts.

Fitness

Save on gym memberships, home fitness products, fitness plans and sports equipment.

Hearing

Pay less for hearing exams, hearing aids, batteries, repairs and other hearing aid services.

LifeMart® shopping website

Save on travel, tickets, electronics, home, auto, family care, groceries, wellness and dining.

Natural products and services

Pay less for over-the-counter vitamins, online medical consultations, spas, yoga and skin care.

Vision

Save on eye exams, frames, lenses, contact lenses and solutions, sunglasses and LASIK surgery.

Weight management

Pay less for weight-loss programs and products, diet and meal plans, and magazine subscriptions.

These programs are not insurance. So there are no claims, no referrals and no limits on how often you can use your discount. It's on-the-spot savings that your covered family members can use, too.

For more details, log on to Aetna Navigator at **www.aetna.com** and click on Coverage & Benefits from the top navigation bar, then click on Discounts. You can also call Member Services at **1-877-512-0363**.

Aetna Mobile

The Aetna Mobile app lets you use features of your secure member website wherever you go. Search claims, find a doctor, get cost estimates, find an urgent care center, pull up your ID card and more. The app is available for Android™ and iPhone® mobile devices.

Two ways to download your FREE Aetna Mobile app:

- Text **Apps** to **23862** to download now.*
- Scan the code with your mobile device.

To learn more, visit **www.aetna.com/mobile**.

*Standard text messaging and other rates from your wireless carrier may apply.

Android and Google Play are trademarks of Google, Inc.

Apple, the Apple logo and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple, Inc.

Health Decision Support

Medical information can be tough to understand, especially when your doctor says you may need surgery or another kind of treatment.

The Health Decision Support tool is a library of online learning programs that:

- Are available 24/7.
- Help you understand how specific conditions impact your body.
- Walk you through tests, procedures or surgery you may be considering.
- Help make complex medical terms easy to understand.
- Help you weigh the benefits and risks of your health care options.
- Help you know how to talk with your doctors about your options.

To access, log on to Aetna Navigator at **www.aetna.com** and click on Care & Treatment from the top navigation bar, then click on Health Decision Support from Emmi.

Your Personal Health Record

Accessed through Aetna Navigator, your Personal Health Record (PHR) provides a single, secure place to record and store your health information. It's a way to keep track of health information and to share it with your doctors. Your PHR is always up to date and organized. Each time Aetna processes a new medical claim — such as a doctor visit or a lab result — it is automatically added to your record.

Even though prescription drug benefits coverage is administered by Express Scripts, the PHR reflects prescription drug claim activity.

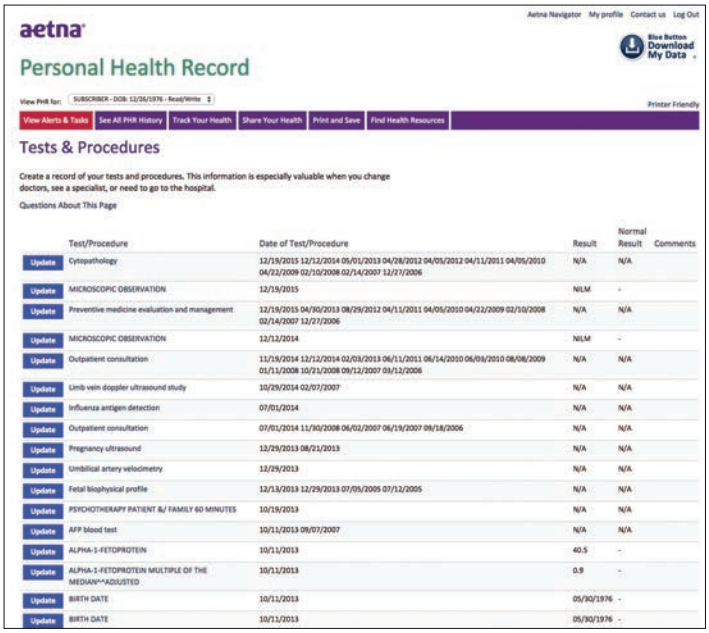
You can also add your own personal medical information to your PHR, including over-the-counter medications, family history and conditions you may not see a doctor for, such as back pain or headaches.

Highlights of your PHR

- Stores and organizes all of your health information.
- Posts alerts and health reminders to remind you about tests and screenings you should have.
- Allows you to add and track health information and obtain emergency information quickly.
- Helps you organize your children's health information, such as immunization records.
- Helps you coordinate care from multiple health care providers.
- Provides educational resources on health topics, such as allergies, immunizations and medications.
- Suggests questions to discuss with your doctor and, if you choose, lets your doctor have access to your PHR. You can also print out a health summary to bring with you to your doctor visit.

To access your PHR, simply log on to Aetna Navigator at **www.aetna.com** and click on Personal Health Record under the Health Records tab. To get started, the "Walk Me Through" tool can help you decide what information to add by guiding you with questions. Or you can explore on your own. Be sure to provide your e-mail address in the Personal Information section so you can receive e-mail notifications when you have new alerts and reminders.

All information is kept confidential, private and secure. Your Company does not have access to your PHR. Only you can access your own PHR unless you choose to allow your doctor to have access. A separate, secure PHR will be available for you and each eligible family member.



Best Doctors

Best Doctors is a separate program that will be offered starting January 1, 2017. Best Doctors can help you with everything from minor surgery to major issues like cancer and heart disease. It's like getting a second opinion, only better. You don't need to travel, visit doctors' offices or chase medical records, and there's no additional cost to you to use this service. You can:

- **Have an expert conduct an in-depth review of your medical case**
  Get a confidential expert report, including recommendations for the best course of action.
- **Get expert advice about medical treatment**
  Get advice about a personal health challenge or medical condition from an expert physician.
- **Find a Best Doctor near you**
  You have access to 53,000+ medical experts voted best-in-class by other physicians.
- **Explore your treatment options before making a decision**
  Know all your options — including drugs and medical procedures — before taking action.

For more information, visit **www.bestdoctors.com/jnj** or call **1-888-260-5130** Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern Time.

Questions?

Log on to Aetna Navigator at **www.aetna.com** or call **1-877-512-0363** any business day from 8:00 a.m. to 7:00 p.m. Eastern Time to reach a dedicated Member Services Representative.

This Guide addresses only particular aspects of the benefits available under the Plan. Various limits, exclusions and other rules apply to these benefits. For a more complete description of the available benefits, see the relevant Plan Details or Summary Plan Description (including any applicable Summary of Material Modifications), other official Plan Documents and, where applicable, insurance contracts. In the case of any discrepancy, these more complete descriptions will govern. Your Company reserves the right to amend or terminate the Plan at any time. Amendment or termination of the Plan may affect the information provided in this Guide. The Plan Details document can be found on the For Your Benefit website, where you can access YBR, at **www.resources.hewitt.com/jnjbsc** (this address is case sensitive, so use lower-case letters).

TTY: 711

For language assistance in your language call 1-877-512-0363 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-512-0363. (Spanish)

欲取得繁體中文語言協助，請撥打1-877-512-0363，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-877-512-0363 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-512-0363 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-512-0363 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-512-0363. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-512-0363 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-512-0363. (Italian)

日本語で援助をご希望の方は、1-877-512-0363 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-512-0363 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 1-877-512-0363 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-512-0363. (Polish)

Para obter assistência linguística em português ligue para o 1-877-512-0363 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-512-0363. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-512-0363. (Vietnamese)