On track

Health Reimbursement Arrangement (HRA) Plan Guide for 2020

aetna
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Applied Behavior Analysis (ABA)
If your child has been diagnosed with an autism spectrum disorder, he or she may be eligible for ABA services. You can call us at 1-877-512-0363 (TTY: 711) for details and requirements.
A partnership for your care

Your health care is a responsibility shared by you, us 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 percent coverage for eligible in-network preventive care and a health reimbursement arrangement (HRA) fund that pays a portion of your annual deductible.

• We offer a network of physicians, hospitals and other health care providers and facilities that have undergone a strict credentialing process.

• Our Member Services and CareConnect teams are fully dedicated to Johnson & Johnson members. They are experts on your plan and are there to answer your questions and support you when you need care.

• We, as well as 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.

• Did you know that your plan is self funded? This means the company provides the money used to pay for eligible medical expenses.

This guide will help you make the most of your HRA Plan benefits and resources.
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 percent) 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 2019 HRA fund and you enrolled in the HRA Plan for 2020, your 2019 rollover amount will be used to help meet your 2020 annual deductible and, if any remains, to help pay your coinsurance for eligible medical expenses. If a claim incurred in 2019 is not submitted or received until 2020, the claim will be paid using your 2019 HRA rollover amount. However, if a claim incurred in 2019 is submitted or received in 2020 after your 2019 HRA rollover is depleted, you will still need to meet your 2019 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 percent and you pay 20 percent of prenegotiated fees. For eligible out-of-network services, the plan pays 60 percent and you pay 40 percent of the recognized 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 percent 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 percent 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 our name for your HRA fund; the two terms refer to the same fund.
## HRA Plan at a glance

### HRA fund and annual deductible

<table>
<thead>
<tr>
<th>Family status category</th>
<th>Annual deductible</th>
<th>HRA fund provided by the company</th>
<th>Amount of annual deductible you pay from HRA rollover or your own monies before you start paying coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>You only</td>
<td>$1,000</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>You + spouse/partner</td>
<td>$1,500</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>You + child(ren)</td>
<td>$1,500</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>You + family</td>
<td>$2,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Coinsurance

<table>
<thead>
<tr>
<th>After your annual deductible is met</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 80% / You pay 20%</td>
<td></td>
<td>Plan pays 60% / You pay 40%</td>
</tr>
</tbody>
</table>

### Out-of-pocket maximum

<table>
<thead>
<tr>
<th>Family status category</th>
<th>Employees with regular annual salary(^2) of more than $70,000</th>
<th>Employees with regular annual salary(^2) of $70,000 or less</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>You only</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>You + spouse/partner</td>
<td>$9,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>You + child(ren)</td>
<td>$9,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>You + family</td>
<td>$12,000</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

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 percent 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 percent for eligible in-network expenses. When your eligible expenses reach the out-of-network out-of-pocket maximum, the plan pays 100 percent 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 2020 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 percent coinsurance for in-network services and 40 percent for out-of-network services

<table>
<thead>
<tr>
<th>Eligible medical expenses for 2020</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HRA fund pays ($1,000 contributed by the company)</td>
<td>$1,000</td>
</tr>
<tr>
<td>2 You pay until the annual deductible is reached</td>
<td>$1,000</td>
</tr>
<tr>
<td>3 Remaining eligible expenses</td>
<td>$8,000</td>
</tr>
<tr>
<td>You pay 20% coinsurance</td>
<td>$1,600</td>
</tr>
<tr>
<td>Plan pays 80%</td>
<td>$6,400</td>
</tr>
</tbody>
</table>

You pay $2,600 and the plan pays $7,400

**Important note:** If you have any HRA rollover it will be used to pay your annual deductible or your share of coinsurance before you pay from your own monies.

**Status:** you + family
- **Annual salary:** over $70,000
- **Annual deductible:** $2,000
- **Medical expenses:** all in-network

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

3. We will process your claim and you will be able to review claim activity on the explanation of benefits (EOB) statement on 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 13-14 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 it 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 percent coinsurance up to the in-network out-of-pocket maximum. If you have any HRA rollover it will be used to pay the 20 percent 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 us and the amount you owe is accurate. You can do this by:
   • Checking your HRA fund and annual deductible activity by logging in to your member website at 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) has been used up — we 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 retired 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 us for consideration. We 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 Medical Benefits Claim Form from the For Your Benefit (FYB) website at fyb.jnj.com. You can also obtain the claim form by logging in to your member website at 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. We 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 your 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 13-14 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 it 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 40 percent coinsurance up to the out-of-network out-of-pocket maximum. If you have any HRA rollover it will be used to pay the 40 percent 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) has been used up — we 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 we are 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 retired 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 us for consideration. We 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 network doctors and facilities, the amount you pay 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 pay — your coinsurance — 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 discount. Reimbursements are based on the recognized 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.

*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.

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 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 owe.

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 area.

Payment is based on the recognized charge, which may be less than the charge submitted by the provider. As part of this process, we 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 (TTY: 711). Since we cannot guarantee a reduction in charges, you may be responsible for paying the remaining balance.

Save on lab work

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 at independent labs, including Quest Diagnostics® and LabCorp. You’ll pay more if you use hospital labs or if you go outside the network.

Independent labs offer other advantages, including:

- Convenience: For online appointment scheduling, visit Quest Diagnostics at QuestDiagnostics.com or LabCorp at LabCorp.com.
- 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.
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 your member website by logging in at Aetna.com.

Instructions and a mailing address are included on the form. It takes about ten working days to process your request. To determine how benefits will be paid, we 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. We will send you our pre-determination of medical benefits, in writing, via regular mail.

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 FYB website at fyb.jnj.com 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 the FYB website.

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 us.
Prescription drug coverage

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.

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 percent 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 Express-Scripts.com/JNJ. This website will also contain information on the amounts applied to 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 and the address for submitting claims. It also reminds you that eligible in-network preventive services are paid at 100 percent.

If you were not enrolled in the Aetna HRA Plan in 2019 but enrolled in it for 2020, or if you changed who is covered in 2020, 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 (TTY: 711) for assistance. Representatives are available Monday through Friday from 8 AM to 7 PM ET.

For a temporary ID card, you may log in to your member website at Aetna.com. If you have not already done so, you must register for your member website to access this and other information. See page 18 for instructions on how to register.
Tracking 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 your member website at Aetna.com.

You may check your HRA fund and HealthAccount balances at any time through your member website at Aetna.com. If you were enrolled in the HRA Plan in 2019, any 2019 HRA fund rollover (up to the amount of the in-network medical out-of-pocket maximum) will be posted on January 2, 2020. (See page 18 to learn more about your member website.)

Retirement HRA

If the balance in your 2019 HRA fund exceeds your 2019 in-network medical out-of-pocket maximum, the excess amount will be placed in a retiree reimbursement account (RRA) after April 1, 2020.

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, 2020, visit the UnitedHealthcare website at UHCRetireeAccounts.com or call Member Services at 1-866-868-0511, Monday through Friday from 8 AM to 8 PM 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 on your member website.*

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, on your member website at Aetna.com.

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 14 for more details).

For details on prescription drug claims, go to Express-Scripts.com/JNJ.

*If you want to receive paper EOBs, you will need to change the default option on your member website.

Turn off paper — default option

When you register for your member website, “Receive documents electronically” is automatically set, and you can view all your EOBs online and not receive any through the mail. You can receive email notification when new EOBs are available if you have registered on your member website.
**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 we process your claims 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.
6. **Payments Made.** The amount we paid, which could be paid from your HRA fund or from our 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 from 2019.
   - **Spent Year-to-Date** – the amount 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 our name for your HRA fund; the two terms refer to the same fund.
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 percent 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 to be covered at 100 percent 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 40 percent 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 FYB website at fyb.jnj.com. 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.

Don’t forget your eyes

Your eyes reflect your health. So it’s good to give them an annual checkup. Your medical plan covers one routine eye exam each year at 100 percent when you visit an eye doctor who participates in the plan. Go to Aetna.com/dse/custom/jnj and search for optometrists or just eye doctors. Or call us at 1-877-512-0363 (TTY: 711).

You can earn points for getting preventive mammograms and colonoscopies (based on preventive service guidelines).

For more information, download the free Castlight app or visit mycastlight.com/jnj. Use “Single Sign-On (SSO)” and enter J&J as the employer name. Sign in with your J&J username and password.
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 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.

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.
• We have been contacted for pre-admission approval of an upcoming inpatient hospitalization or when 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 23 for more information).

Preventive care reminders will be sent to you via your PHR. In addition to these reminders, we will also send you letters. If you receive a letter (see the sample below) and/or message from us, you should know that this is a service provided through the CareConnect program.

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. For information about such things as making a living will, durable power of attorney and finding hospice care, visit AetnaCompassionateCare.com.

March 26, 2020

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 1-800-319-4864, 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.

Your Care Consideration

Preventive care reminders will be sent to you via your PHR. In addition to these reminders, we will also send you letters. If you receive a letter (see the sample below) and/or message from us, you should know that this is a service provided through the CareConnect program.

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. For information about such things as making a living will, durable power of attorney and finding hospice care, visit AetnaCompassionateCare.com.
Obtain valuable services by contacting CareConnect directly

You can contact CareConnect directly by calling 1-877-512-0363 (TTY: 711) any business day from 8 AM to 7 PM ET. 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 minor 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 (TTY: 711) any business day from 8 AM to 7 PM ET, or view the CareConnect brochure by logging in to your member website at Aetna.com or on the FYB website at fyb.jnj.com.

A commitment to your privacy

We are 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

Log in to Aetna.com to access your personalized and secure member website. Your first step is to register and set up your user name and password:

1. **Click on the Login box.**
   Your spouse/partner and dependent children ages 18 or older can set up their own accounts. Dependents do not have access to all the features of the site, 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 the site, such as:

**Find Care & Pricing**

- Use the online provider directory to find health care professionals and facilities that participate in the plan.

For many services you can see an estimated cost based on your plan specifics. You can compare the estimate with other providers and make an informed decision about where to receive care.

You may access the directory through your member website or at Aetna.com/dse/custom/jnj. When prompted to Select a Plan, you’ll need to select the HRA Plan.

**Manage**

- **Claims** – Review and download claims details.
- **Explanation of Benefits (EOB)** – View your EOB statements.

**See Coverage & Benefits**

- **Plans** – View coverage for yourself and your family members.
- **Account balances** – Find HRA fund and HealthAccount balances.
- **Spending summary** – Check your deductible and coinsurance balances.

**Stay Healthy**

- **Health Programs** – Access your health programs like personal health record, health decision support and Healthy Lifestyle Coaching.
- **Discounts** – Learn how to use your Aetna discounts.
- **Healthwise® Knowledgebase** – Get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.
- **Health decision support from Emmi** – Learn more about conditions and treatment options.
- **Maternity Support Center** – Find resources to help you through each stage of your pregnancy journey.

**Cancer Support Center**

- Get education, tips and tools for breast, colorectal, lung, prostate and women’s reproductive cancers.

**Take care of administrative tasks**

- **ID cards** – View and print ID cards for yourself and your family members.
- **Profile** – Update your preferences and personal information.
- **Contact us** – Contact Aetna Member Services by phone, mail or secure email.

**Johnson & Johnson information**

- At the bottom of the page, you’ll find links to additional information specific to Johnson & Johnson benefits.
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.

Behavioral health support

Teladoc’s behavioral health professionals can help with addiction, depression, mental/physical challenges, family difficulties and other challenges.

Your cost for a Teladoc behavioral health consultation (video 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

Skin care

You can access licensed dermatologists without leaving home. They can treat ongoing or complex skin conditions like psoriasis, skin infection, rosacea, suspicious moles and many more. Simply log in to your account and upload images of your issue. You will receive a response online through Teladoc’s message center within two business days. The cost for a consult is $75, which includes a free follow-up visit within 7 days.

All other Teladoc consultations are $40. Once you meet your annual deductible, all Teladoc consultations are covered at 100 percent.

Earn points with Teladoc

You can earn points for learning about Teladoc and creating an account.

For more information, download the free Castlight app or visit mycastlight.com/jnj. Use “Single Sign-On (SSO)” and enter J&J as the employer name. Sign in with your J&J username and password.

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

If you are a new Aetna member, 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 Teladoc.com/Aetna.
AbleTo

Some life events can be overwhelming. Like having a baby. Or finding out you have diabetes or heart disease. They can hinder your ability to take control and make healthy lifestyle changes. AbleTo is an eight-week program that offers emotional support when you need it.

Real help that works

Web-based video conferencing makes it possible for you to meet face-to-face with your team. Or you can simply talk on the phone if you prefer.

Consider AbleTo support if you have experienced one of these health conditions or life changes:

- Breast and prostate cancer recovery
- Caregiver status (child, elder, autism)
- Depression/anxiety
- Diabetes
- Digestive health
- Grief and loss
- Heart problems
- Military transition
- Pain management
- Postpartum depression
- Respiratory problems
- Substance abuse

How to get started

Call AbleTo at 1-844-330-3648 Monday through Friday from 9 AM to 8 PM ET.

Behavioral health televideo

You can access behavioral health televideo counseling services from anywhere. Meet with a counselor at your convenience. Just use your webcam on any computer or smart device.

A behavioral health televideo session will cost the same as a face-to-face office visit.

Call a provider group in your area to get private, confidential help with anxiety, depression, stress, substance abuse and addiction, family issues, and more:

<table>
<thead>
<tr>
<th>Call</th>
<th>At</th>
<th>If you live in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpathy®</td>
<td>1-800-442-8938</td>
<td>California, Delaware, Missouri, New Jersey, New York, Pennsylvania, Virginia</td>
</tr>
<tr>
<td>MDLIVE®</td>
<td>1-888-282-2522</td>
<td>Kentucky, Louisiana, Missouri, Oklahoma, Oregon, Texas</td>
</tr>
<tr>
<td>Arcadian Telepsychiatry</td>
<td>1-866-991-2103</td>
<td>All other states</td>
</tr>
</tbody>
</table>
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 (TTY: 711) Monday through Friday from 8 AM to 10 PM ET.

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.

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.

Lasik surgery
Get discounts on screening, surgery and follow-up care.

LifeMart® shopping website
Save on travel, tickets, electronics, home, auto, family care, wellness and dining.

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

Oral health
Save on Sonic toothbrushes, replacement heads and oral health care kits.

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 in to your member website at Aetna.com or call Member Services at 1-877-512-0363 (TTY: 711).
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 in to your member website at Aetna.com.

Aetna Health℠ app

Your Aetna Health app is personalized to accommodate your schedule, health needs and communication preferences. You’ll get the tools you need to meet your most important health goals.

You’ll be able to:
- Pay claims
- View benefits
- Search for providers and procedures
- Get cost estimates before you get care
- Track spending and progress toward meeting your deductible
- Access your member ID card whenever you need it

Download the Aetna Health app from your app store or text “AETNA” to 90156 for a link.

Best Doctors

Best Doctors is a separate program that 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 BestDoctors.com/JNJ or call 1-888-260-5130, Monday through Friday from 8 AM to 9 PM ET.
Your personal health record

Accessed through your member website, 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 we process 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 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, log in to your member website at Aetna.com. Be sure to provide your email address in the Personal Information section so you can receive email 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.
Questions

Log in to your member website at Aetna.com or call 1-877-512-0363 (TTY: 711) any business day from 8 AM to 7 PM ET 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 FYB website at fyb.jnj.com.

TTY: 711

To access language services at no cost to you, call 1-877-512-0363 .

Para acceder a los servicios de idiomas sin costo, llame al 1-877-512-0363 . (Spanish)

如欲使用免費語言服務，請致電 1-877-512-0363 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-512-0363 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-512-0363 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-512-0363 an. (German)

( Arabic )

تحصل على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-512-0363.

Pou jwenn sèvis lang gratis, rele 1-877-512-0363 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-512-0363 . (Italian)

言語サービスを無料でご利用いただくには、1-877-512-0363 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-877-512-0363 번으로 전화해 주십시오. (Korean)

( Persian-Farsi )

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-512-0363 تماس بگیرید.

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-877-512-0363 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-512-0363 . (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-512-0363 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-512-0363 . (Vietnamese)