This guide will help you make the most of your Separation Medical Plan benefits and resources. Please call Member Services if you have any questions.

- 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.

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4 How to pay for medical services
8 Prescription drug coverage
9 ID cards
9 Tracking your costs and claims
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12 CareConnect
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Applied Behavior Analysis (ABA)
If your child has been diagnosed with 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.
How the Separation Medical Plan works

The Separation Medical 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. The annual deductible is $500 per covered individual up to a maximum of $1,500 per family.

2. **Inpatient deductible**
   This is the amount of eligible inpatient expenses you are responsible for paying before the plan begins to pay a percentage of eligible expenses for an inpatient admission. The inpatient deductible is $400 per admission. There is a maximum of two inpatient deductibles per family per plan year.

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 80 percent and you pay 20 percent of the recognized charge. (You must pay any fees in excess of the recognized charge.)

4. **Medical out-of-pocket maximum**
   Your eligible in-network and out-of-network medical expenses (excluding eligible in-network preventive care and prescription drug expenses) both count toward the medical out-of-pocket maximum. When your eligible expenses reach your medical out-of-pocket maximum, the plan pays 100 percent for eligible in-network expenses and 100 percent of the recognized charge for eligible out-of-network expenses for the remainder of the plan year (you must pay any fees in excess of the recognized charge). The medical out-of-pocket maximum is $3,500 per covered individual up to a maximum of $7,000 per family.
## Separation Medical Plan at a glance

<table>
<thead>
<tr>
<th></th>
<th>In-network and out-of-network</th>
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<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
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<tr>
<td>You only</td>
<td>$500</td>
</tr>
<tr>
<td>You + family</td>
<td>$1,500</td>
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<tr>
<td><strong>Inpatient deductible</strong></td>
<td>$400 per inpatient admission</td>
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<td></td>
<td>Maximum two per family per year</td>
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<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% / you pay 20%</td>
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<tr>
<td>After your annual deductible is met</td>
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<tr>
<td><strong>Medical out-of-pocket maximum</strong></td>
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<td>You only</td>
<td>$3,500</td>
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<tr>
<td>You + family</td>
<td>$7,000</td>
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Any combination of eligible medical expenses from one or more covered family members can satisfy the annual deductible and the medical out-of-pocket maximum. However, no one family member can satisfy more than the individual annual deductible ($500) or medical out-of-pocket maximum ($3,500).
# How to pay for medical services

## How the process works — **in-network** medical claims

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Present your Separation Medical Plan ID card (called Open Choice PPO) to the provider at the time of the visit. If you are enrolled in Medicare, also present your Medicare ID card when you visit your doctor.</td>
</tr>
<tr>
<td>2</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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 page 10 for information about EOBs.  
  a. Covered expenses (except eligible in-network preventive care and prescription drug expenses) are applied to your annual deductible.  
  b. After you have met your annual deductible, you are responsible for the 20 percent coinsurance up to the annual out-of-pocket maximum.  
  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 Separation Medical 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 activity by logging in to your member website at Aetna.com  
  • Checking the EOB  
  • Calling Member Services to check the status of your claim |

### 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 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 Separation Medical 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 Separation Medical Plan ID card (called Open Choice PPO) to the provider at the time of the visit. If you are enrolled in Medicare, also present your Medicare ID card when you visit your doctor.

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 digital.alight.com/jnjbsc (this address is case sensitive, so use lower case letters). 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 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 page 10 for information about EOBs.
   a. The covered expenses (except prescription drug expenses) will be applied to your annual deductible.
   b. After you have met your annual deductible, you are responsible for the 20 percent coinsurance up to the annual out-of-pocket maximum.
   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 Separation Medical Plan, your provider will send you a bill.

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 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 Separation Medical 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.

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.

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 digital.alight.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 the FYB website.
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 or the medical out-of-pocket maximum.

**Annual prescription drug out-of-pocket maximum**

The Separation Medical Plan has a separate annual prescription drug out-of-pocket maximum.

If you are enrolled for “you only” coverage, your prescription drug out-of-pocket maximum is $2,000; if you are also covering any eligible dependent(s), your prescription drug out-of-pocket maximum is $4,000. Any combination of eligible prescription drug expenses from one or more covered family members can satisfy your prescription drug out-of-pocket maximum; however, no one family member can count more than $2,000 toward the family out-of-pocket maximum.

Express Scripts will keep track of the prescription drug coinsurance amounts you pay at your local pharmacy and through home delivery. Once the prescription drug out-of-pocket maximum is reached, eligible prescription drugs will be covered at 100 percent for the remainder of the plan year.

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 maximum.

**Special note to Medicare-eligible members**

Any individual who is eligible for Medicare will be automatically enrolled in the company-sponsored Medicare Part D prescription drug plan through Express Scripts. The prescription drug out-of-pocket maximum is not applicable to this Plan. Contact Express Scripts Medicare Member Services at 1-877-891-1143 for specific questions about this Plan.
ID cards

Your ID card is your passport to access the Separation Medical 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.

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 14 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 that are available on your member website at Aetna.com.
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), 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.

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.
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 Separation Medical 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 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 20 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 digital.alight.com/jnjbsc. These preventive services include but are not limited to the U.S. Preventive Services Task Force (USPSTF) recommendations. The Separation Medical 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).
CareConnect

What is CareConnect?
CareConnect is a free, voluntary and confidential program offered directly through your Separation Medical 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 18 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 CareSM 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.

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**March 26, 2020**

SAM SAMPLE
123 THAT STREET
THATVILLE, NY 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 1-800-529-4954, Monday–Friday, from 8:30 am to 5:30 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**
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 digital.alight.com/jnjbsc.

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.
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 Separation Medical 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.
- **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.
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:

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<th>Call</th>
<th>At</th>
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<tbody>
<tr>
<td>Inpathy®</td>
<td>1-800-442-8938</td>
<td>California, Delaware, Missouri, New Jersey, New York, Pennsylvania, Virginia</td>
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<tr>
<td>MDLIVE®</td>
<td>1-888-282-2522</td>
<td>Kentucky, Louisiana, Missouri, Oklahoma, Oregon, Texas</td>
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<tr>
<td>Arcadian Telepsychiatry</td>
<td>1-866-991-2103</td>
<td>All other states</td>
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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 digital.alight.com/jnjbsc (this address is case sensitive, so use lower-case letters).

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)

如欲使用免费语言服务，请致电 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) للحصول على خدمات اللغة 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 linguisticì, 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)
Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance company and its affiliates (Aetna). Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See your Summary Plan Description for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to Aetna.com.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-877-512-0363 (TTY: 711).

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@Aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).