Go for it

Premier HSA Plan Guide for 2022

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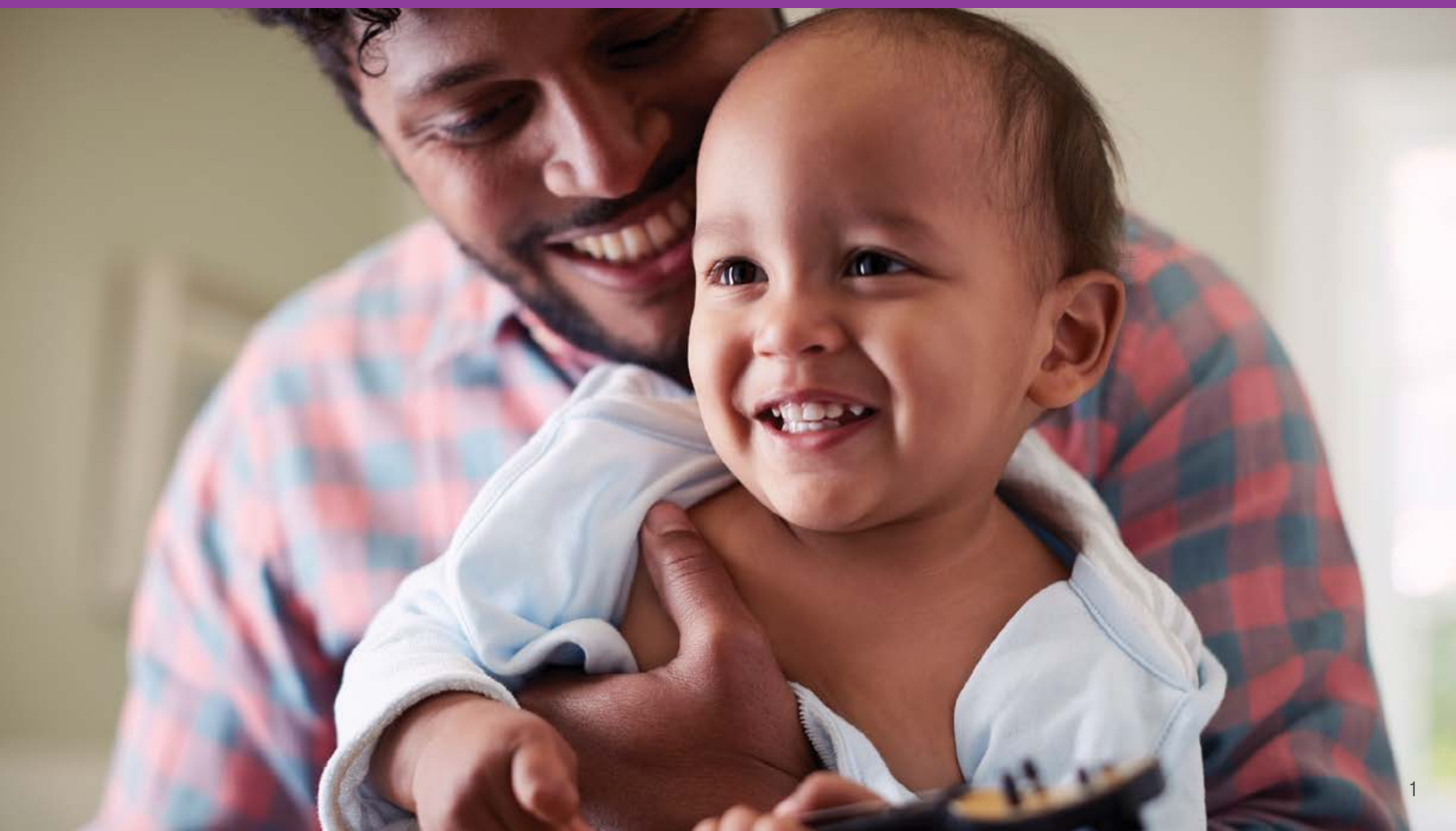
Your plan covers **hearing aids**. You can call Member Services at **1-877-512-0363 (TTY: 711)** for details and requirements.



A partnership for your care

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

- Johnson & Johnson provides a health care plan with 100% coverage for eligible in-network preventive care. They also offer a health savings account (HSA), which consists of funds from the company based on your level of coverage plus your optional pre-tax contributions. You can use your HSA toward eligible medical and prescription drug expenses, including your annual deductible.
- Aetna offers 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're 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 available to you and make informed health care decisions to optimize your health.
- Did you know that your plan is self-funded? This means that Johnson & Johnson provides the money used to pay for eligible medical expenses.

This guide will help you make the most of your Premier HSA Plan benefits and resources.

How the Premier HSA Plan works

The Premier HSA Plan has three main parts

1 **Annual deductible**

This is the amount of eligible medical and prescription drug expenses you must pay each plan year before the plan begins to pay a percentage of those expenses.

2 **Coinsurance**

After you meet the annual deductible, you and the plan share the cost of eligible services. This cost-sharing is called coinsurance. For eligible in-network services, the plan pays 80% and you pay 20% of pre-negotiated fees. For eligible out-of-network services, the plan pays 60% and you pay 40% of the recognized charge. You are responsible for any fees in excess of the recognized charge.

3 **Out-of-pocket maximum**

Your eligible in-network and out-of-network medical and prescription drug expenses count toward the out-of-pocket maximums. Routine preventive care is covered at 100% and doesn't count toward the out-of-pocket maximum. After you reach your in-network out-of-pocket maximum, the plan pays 100% for eligible in-network expenses for the rest of the plan year. When your eligible expenses reach your out-of-network out-of-pocket maximum, the plan pays 100% for eligible out-of-network expenses for the rest of the plan year. You're responsible for any fees over the recognized charge.

Health savings account (HSA)

The HSA is a tax-favored account set up for you by the company and administered by Bank of America. Here's how it works:

Contributions

At the beginning of the plan year, the company makes a contribution to your Bank of America HSA. You may contribute, as well, up to limits set by the Internal Revenue Service. These limits include the company contribution, contributions you elect to make through automatic pre-tax payroll deductions and payments you make directly to Bank of America. See page 4 for details.

Catch-up contributions of $1,000 are allowed for individuals who are 55 and older. You may change the amount of your contribution at any time during the plan year. Voluntary payroll contributions to your HSA don't automatically carry over from one year to the next. Each plan year, you'll need to decide whether or not to elect voluntary payroll contributions and designate the amount you want to contribute.

Family status category	2022 contribution maximum	Company contribution	Employee voluntary contribution maximum
You only	$3,650	$500	$3,150
You + spouse/partner	$7,300	$1,000	$6,300
You + child(ren)	$7,300	$1,000	$6,300
You + family	$7,300	$1,000	$6,300

Important note: Company contributions to the HSA are only available for active employees.

Using your HSA

You decide when and how to use your HSA to pay for qualified medical expenses during the plan year. You may pay expenses out of your own pocket for your annual deductible or coinsurance amount. Then you may either reimburse yourself from your HSA or choose to let your account grow for future needs or investments.

If you choose to pay for qualified medical expenses from your Bank of America HSA, you can do so using any of the following methods:

- **HSA debit card:** The debit card will be sent to you prior to your health plan taking effect and can be used by any health care provider that accepts Visa®.
- **HSA online bill pay:** Once enrolled, you can set up payees and make payments for qualified medical expenses from the Bank of America website at **MyHealth.BankofAmerica.com**.
- **Self-reimbursement:** Once your HSA is open, if you pay for a qualified medical expense out of pocket, you can reimburse yourself at any time using the Pay Self function on **MyHealth.BankofAmerica.com**.

Tax advantages

The HSA offers some tax advantages:

- Contributions are made with pre-tax dollars, lowering your taxable income and the amount you pay in federal, certain state and other applicable taxes.
- Balances earn interest tax free.
- Withdrawals for qualified expenses are tax free.

Qualified medical expenses are defined by IRS Code 213(d) and include your annual deductible. For a complete list (IRS Publication 502), call **1-800-829-3676** or visit **IRS.gov** and click on Forms & Instructions.

Be sure to save your receipts when you use your HSA debit card. If you use the card or your HSA for non-qualified expenses, you will need to report it on your tax return and pay any applicable taxes.

Growing your account

Similar to a standard checking account, you own your HSA and any dollars deposited into the cash account. Cash account balances are FDIC insured, earn interest and roll over from year to year. You can invest any dollar amount in excess of the $1,000 minimum balance required to be held in your cash account. You may choose from several investment options. If you leave the company, you may take your HSA, including your investment account, with you. However, you can only continue contributing to the HSA if you're covered by a qualified high deductible health plan.

You may check your HSA balance online or via your mobile phone at **MyHealth.BankofAmerica.com**. You must be registered with the site.

After you enroll in your HSA, Bank of America will send you a welcome kit. Your HSA debit card will be mailed separately. You will need to activate your HSA debit card by calling the number on the sticker on your debit card.

Bank of America will provide quarterly account statements showing all activity to your HSA via the website **MyHealth.BankofAmerica.com**.

Premier HSA Plan at a glance

HSA and annual deductible		
Family status category	Annual deductible	Annual HSA contribution provided by the company
You only	$1,400	$500
You + spouse/partner	$2,800	$1,000
You + child(ren)	$2,800	$1,000
You + family	$2,800	$1,000

Coinsurance		
	In network	Out of network
After your annual deductible is met	Plan pays 80%/You pay 20%	Plan pays 60%/You pay 40%

Out-of-pocket maximum[1]				
Family status category	Employees with regular annual salary[2] of more than $85,000		Employees with regular annual salary[2] of $85,000 or less	
	In network	Out of network	In network	Out of network
You only	$3,500	$7,000	$2,500	$5,000
You + spouse/partner	$5,250	$10,500	$3,750	$7,500
You + child(ren)	$5,250	$10,500	$3,750	$7,500
You + family	$7,000	$14,000	$5,000	$10,000

Any combination of eligible medical and prescription drug expenses from one or more covered family members can satisfy the annual deductible and the out-of-pocket maximums.

[1]Your eligible in-network and out-of-network expenses both count toward the out-of-pocket maximums. When your eligible expenses reach the in-network out-of-pocket maximum, the plan pays 100% for eligible in-network expenses. When your eligible expenses reach the out-of-network out-of-pocket maximum, the plan pays 100% for all eligible expenses.

[2]Your "regular annual salary" does not include overtime, bonuses or any other additional compensation. For non-management salespersons, regular annual salary includes the previous year's paid commissions. Annual salary eligibility is based on regular salary as of July 1 from the plan year before.

How to pay for medical services

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

1 Show your Aetna Premier HSA Plan ID card (also called Choice POS II) to the provider at the time of the visit.

2 Your provider may ask you to pay your portion of your annual deductible or coinsurance at the time of the visit. If so, ask that the office staff submit a claim on your behalf.

3 We'll process your claim. You'll be able to review claim activity (except for drugs processed by Express Scripts) on the Explanation of Benefits (EOB) statement on your member website. The EOB will show whether your plan covered the services received and if so, what part of the covered services your plan paid. See page 13 for information about EOBs.

a. Covered expenses (including prescription drug expenses, but excluding eligible in-network preventive care) that you pay out of pocket are applied to your annual deductible. You may use your HSA to pay your annual deductible.

b. After you meet your annual deductible, you're responsible for the 20% coinsurance up to the in-network out-of-pocket maximum. You may use your HSA to pay your coinsurance amounts.

c. Your provider will send you a bill for any remaining annual deductible and coinsurance you owe. You can then determine whether to pay from your HSA or out of your own pocket. If the expense is not eligible for payment under the Premier HSA 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:

- Logging in to your member website at **Aetna.com**
- Checking the EOB
- Calling Member Services to check the status of your claim at **1-877-512-0363 (TTY: 711)**

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'll then process your claim on a secondary basis to Medicare.

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

How the process works — **out-of-network** medical claims

1 Show your Aetna Premier HSA Plan ID card (also called Choice POS II) to the provider at the time of the visit.

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

3 Get an Aetna® Medical Benefits Claim Form from the For Your Benefit (FYB) website at **fyb.jnj.com**. You can also get the claim form by logging in to your member website at **Aetna.com** or by calling Member Services. After you complete the claim form, attach the bill from your provider and mail it to the address on the back of your ID card.

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

4 We'll process your claim. Reimbursement will be based on your out-of-network benefit and the recognized charge. You're responsible for any amount over the recognized charge. You'll be able to review claim activity on the Explanation of Benefits (EOB) statement on your member website. The EOB will show whether your plan covered the services received and if so, what part of the covered services your plan paid. See page 13 for information about EOBs.

a. Covered expenses (including prescription drug expenses) are applied to your annual deductible **except for certain drugs on the Express Scripts Drug List**. You may use your HSA to pay your annual deductible.

b. After you meet your annual deductible, you're responsible for the 40% coinsurance up to the out-of-network out-of-pocket maximum. You may use your HSA to pay your coinsurance amounts.

c. Your provider will send you a bill for any remaining annual deductible and coinsurance you owe. You can then determine whether to pay from your HSA or out of pocket. If the expense is not eligible for payment under the Premier HSA Plan, your provider will send you a bill.

Important note: If you're enrolled in the Premier HSA Plan, you cannot be enrolled in the Health Care Flexible Spending Account (FSA).

Important information on certain out-of-network providers

When an out-of-network provider offers to accept the plan's payment as full payment for a service and waive any amount (annual deductible or coinsurance) normally owed by the patient, this is considered fee forgiving. When we're 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'll then process your claim on a secondary basis to Medicare.

If you or a covered dependent is eligible for Medicare but hasn'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 Premier HSA Plan will be secondary to Medicare Part A and Part B regardless of whether the individual has enrolled in Medicare Part A and B. This could result 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're 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 in 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 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'll review your claim and compare it to industry data to determine the recognized charge and how much you owe.

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:

- 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 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 can't 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 ahead of time if the plan will cover a service, supply or treatment, and how benefits will be paid. 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 10 working days to process your request. To determine how benefits will be paid, we take into consideration whether the care is medically necessary, whether the charge is the recognized charge and whether your doctor is an approved provider for the care. We'll 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's no 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 **fyb.jnj.com** within 60 days after the qualified status change. You'll need to 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're new to the plan, Express Scripts will provide you with a welcome package that explains the services they offer. Express Scripts prescription drug ID cards will 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.

Important note: Certain prescription drugs are covered without having to satisfy the annual deductible, subject to plan provisions. Please refer to the **Prescription Drugs that do not require a Deductible under the Premier HSA Medical Plan** document on the Express Scripts website — **Express-Scripts.com/JNJ** — or on the FYB website. Expenses for prescription drugs continue to count toward the annual deductible and the out-of-pocket maximums. You may choose to pay prescription drug expenses out of your pocket or with your HSA.

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

If you're new to Express Scripts, you'll receive a separate prescription drug ID card once 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 deductible and out-of-pocket maximums.

ID cards

Your ID card is your passport to access the Premier HSA Plan, so it's important that you present your Aetna® 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%.

If your salary tier changes for 2022 (see chart on page 5), you'll get a new ID card in one of two ways:

1. If you've registered for your member website, you'll get a new digital ID card that you can access on your member website or Aetna Health℠ app whenever you need it.
2. If you're not registered, you'll get your new ID card in the mail.

You can request a physical ID card through your member website.

If you were not enrolled in the Premier HSA Plan in **2021** but enrolled in it for **2022**, or if you changed who is covered for **2022**, 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.

You can view, print and share your ID card anytime when you log in to your member website at **Aetna.com**. You can also view and share your card from the Aetna Health app. Be sure to register for your member website to access this and other information.

Tracking your costs and claims

You can track costs and claims for yourself and your covered dependents by reviewing the EOB statements available on your member website through **Aetna.com**.

You can also access your HSA balance at any time at **MyHealth.BankofAmerica.com**. For your convenience, a link to this website is located on your member website.

Retirement HRA

If you were enrolled in the HRA Plan in **2021**, moved to the Premier HSA Plan in **2022** and have a balance in your **2021** HRA rollover account, the entire amount will be placed in a retiree reimbursement account (RRA) after **April 1, 2022**.

This RRA will be an inactive 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, 2022**, visit the UnitedHealthcare website at **www.UHCRetireeAccounts.com** or call their Member Services at **1-866-868-0511**, Monday through Friday from 8 AM to 8 PM local time.

EOB statements

Explanation of Benefits (EOB) statements show the details of claims that have been processed. They're available on your member website. If you want to receive paper EOBs, you can change the default option on your member website.

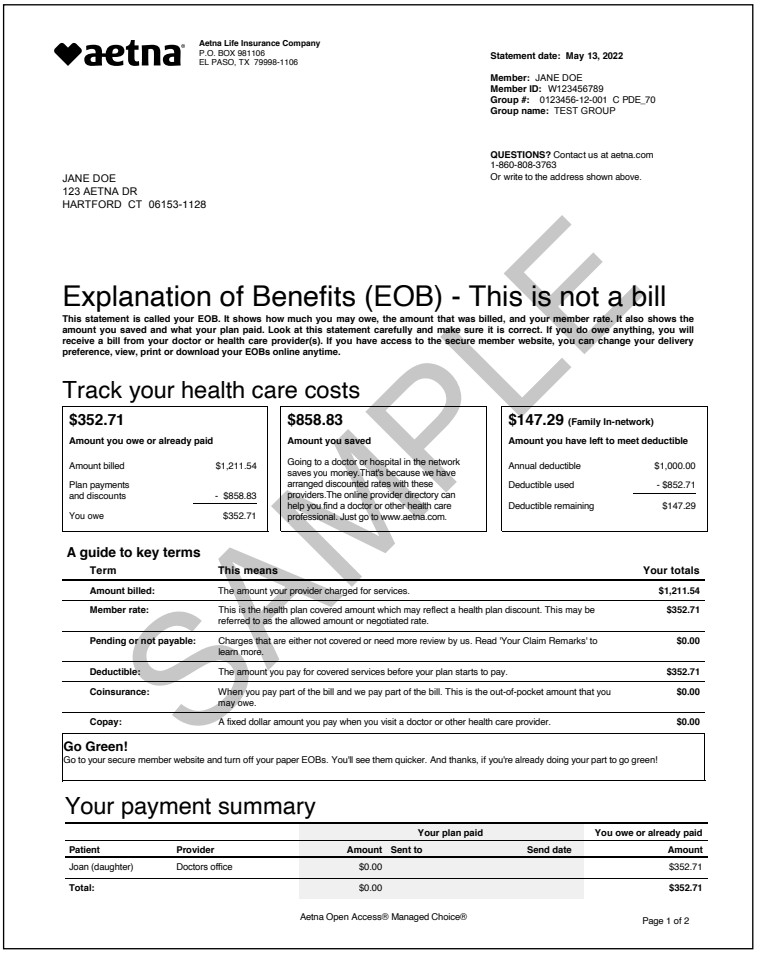
After every medical claim is processed (including if a claim is denied, on hold awaiting additional information, or if a payment is due to you or a provider), the EOB will show:

- The individual claim details, including what the plan pays and your responsibility.
- Year-to-date details of claims 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**.

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've registered on your member website.



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

Statement date: May 13, 2022

Member: JANE DOE
Member ID: W123456789
Group #: 0123456-12-001 C PDE_70
Group name: TEST GROUP

QUESTIONS? Contact us at aetna.com
1-860-808-3763
Or write to the address shown above.

JANE DOE
123 AETNA DR
HARTFORD CT 06153-1128

SAMPLE

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBs online anytime.

Track your health care costs

$352.71
Amount you owe or already paid

Amount billed	$1,211.54
Plan payments and discounts	- $858.83
You owe	$352.71

$858.83
Amount you saved

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

$147.29 **(Family In-network)**
Amount you have left to meet deductible

Annual deductible	$1,000.00
Deductible used	- $852.71
Deductible remaining	$147.29

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	**$1,211.54**
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	**$352.71**
Pending or not payable:	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	**$0.00**
Deductible:	The amount you pay for covered services before your plan starts to pay.	**$352.71**
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	**$0.00**
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	**$0.00**

Go Green!
Go to your secure member website and turn off your paper EOBs. You'll see them quicker. And thanks, if you're already doing your part to go green!

Your payment summary

		Your plan paid			You owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
Joan (daughter)	Doctors office	$0.00			$352.71
Total:		$0.00			**$352.71**

Aetna Open Access® Managed Choice®

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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 at increased risk (for example, a family history) for a particular disease or medical condition.

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

- No cost to you
- No annual deductible to meet

Make sure your doctor submits these services as preventive care. That way they'll be covered at 100% in network. This also includes lab or diagnostic tests that are part of your visit but don't take place in your provider's office.

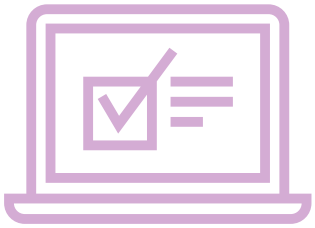
If you use an **out-of-network provider**, you must first meet the annual deductible and then pay the 40% coinsurance, subject to the recognized charge, just as you would for any other eligible out-of-network expense.

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 Premier HSA Plan complies with the USPSTF recommendations as required by the 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% when you visit an eye doctor who participates in the plan. Go to **http://Aetna.com/dse/custom/jnj** and search for optometrists or eye doctors. Or call Member Services at **1-877-512-0363 (TTY: 711)**.



Earn 1,000 points in Castlight to secure your 2022 Medical Contribution Discount (MCD). You can earn points for getting preventive mammograms and colonoscopies (based on preventive services guidelines).

For more information, download the free Castlight app or visit **MyCastlight.com/jnj**. Use "Single sign-on (SSO)" and enter Johnson & Johnson as the employer name. Sign in with your J&J user name and password.

CareConnect

What is CareConnect?

CareConnect is a free, voluntary and confidential program offered through your Premier HSA Plan. CareConnect connects you with experienced professionals with knowledge and understanding of specific health care issues and situations. The program helps you manage acute and complex medical conditions. It also provides resources if you have questions about a chronic condition.

About the CareConnect team

The CareConnect team includes registered nurses, oncology and transplant experts, and other health care professionals who work together with a medical director. The program 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

A CareConnect registered nurse or other CareConnect health care professional may reach out. Or you may get a letter from the CareConnect team if claims data shows that you or a covered dependent:

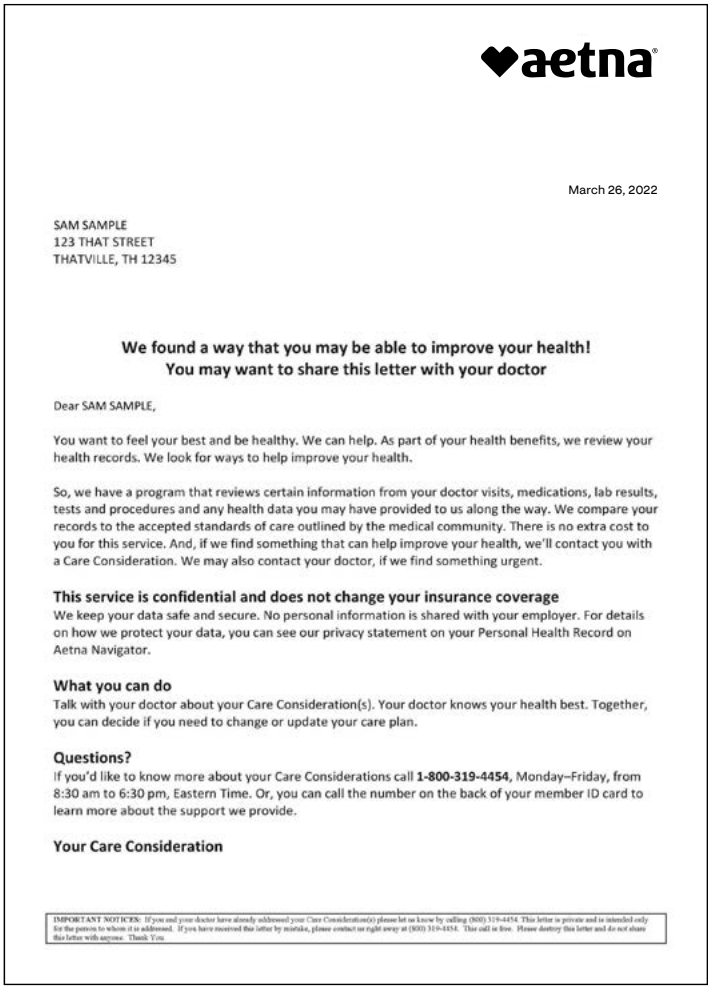
- Have a particular condition, such as cancer, a serious injury or an organ transplant
- Need approval for an upcoming inpatient hospitalization or a hospitalization has occurred

Additionally, CareConnect will send you a letter when they notice an opportunity to ensure that you or a covered dependent is receiving the right care for your age, gender or health status, such as lab tests that should be performed on a regular basis for a specific condition. A letter is also sent to your doctor, and the message appears on your personal health record (PHR). See page 22 for more information.

Preventive care reminders will also be sent to you via your PHR, as well as by letter.

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, the Aetna Compassionate Care℠ program offers service and support. For information on topics such as making a living will, durable power of attorney and finding hospice care, visit **Aetna.com**.



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March 26, 2022

SAM SAMPLE
123 THAT STREET
THATVILLE, TH 12345

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

Dear SAM SAMPLE,

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

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

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

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

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

Your Care Consideration

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

Reach out to CareConnect directly

Call CareConnect at **1-877-512-0363 (TTY: 711)** any business day from 8 AM to 7 PM ET. They can answer questions about a new diagnosis, suggested treatment, side effects, and more for example:

- If your minor child is scheduled for surgery and you want to review what to expect during admission and after discharge, including post-surgical care, physical therapy and any necessary home health care.
- If your spouse had a heart attack and wants their medical information reviewed in order to discuss topics such as these with their doctor:
  - Their health status
  - What may have led to the heart attack
  - Steps for recovery
  - Recommended medications and any possible side effects
  - Activities to help regain mobility
- If you were recently diagnosed with cancer and want to talk with a CareConnect nurse about the most appropriate treatment and to confirm what is covered under your plan. They can even talk with your doctor to help coordinate your care.

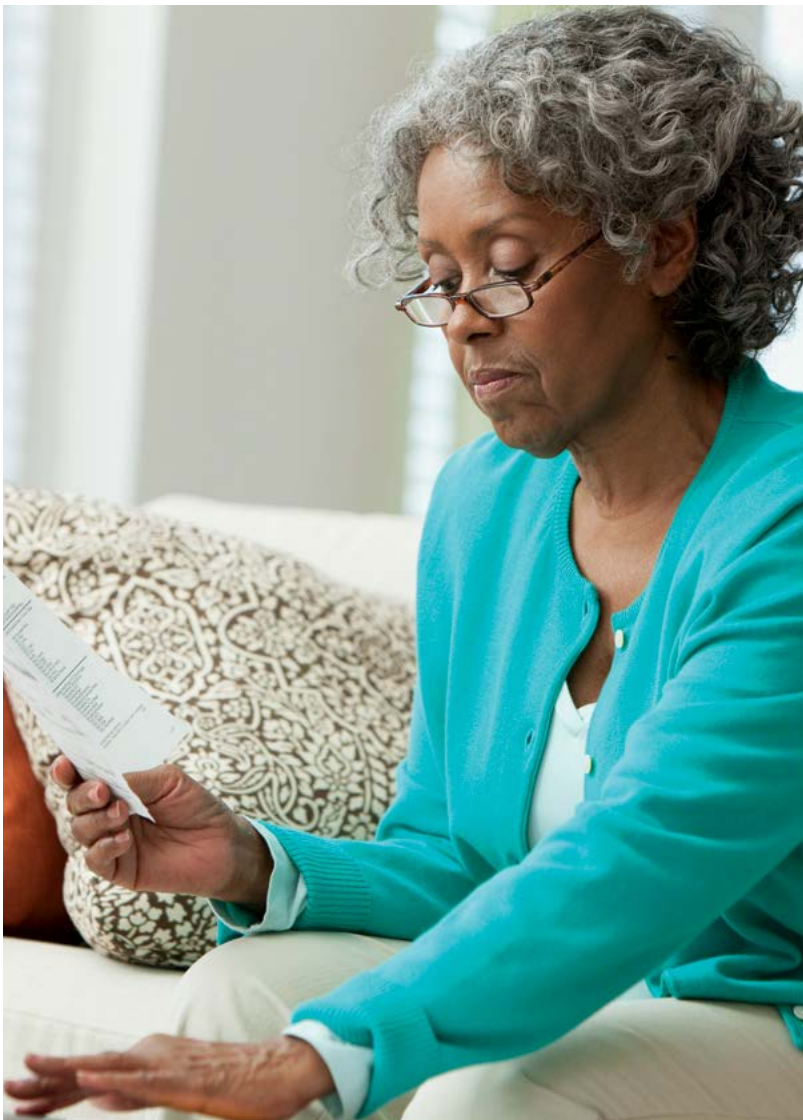
For more information about CareConnect, call **1-877-512-0363 (TTY: 711)** any business day from 8 AM to 7 PM ET. You can also view the CareConnect brochure by logging in to your member website at **Aetna.com** or on the FYB website at **fyb.jnj.com**.

A commitment to your privacy

We're committed to protecting your privacy. Your personal health information will be kept strictly confidential in accordance with privacy policies and law, including 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's no cost to you for participating in CareConnect.

CareConnect supports the patient-doctor relationship — it doesn't 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 tools to help you make informed decisions, find useful information, and get the care you need to stay healthy. You can also save money through special discount programs.

Your Aetna member website and Aetna Health℠ app

Access your benefits, your way — at home or on the go.

Connect to care and stay healthy

- Find in-network providers, including those offering telemedicine services.
- Find walk-in clinics and urgent cares near you.
- Get cost estimates before you get care.
- View provider ratings and reviews.
- Receive personalized reminders to help you improve your health.

Understand and manage your benefits

- Review benefits and coverage details specific to your plan.
- See what your health care costs and how much is covered by your plan.
- See where you are with your deductible and out-of-pocket maximum.
- Access your ID card whenever you need it.

Note: HSA balances can be found on the Bank of America website. A link to this website is located on the bottom of your member website home page.

Manage claims

- View and pay claims.
- View your Explanation of Benefits (EOB) statements.

Health and wellness tools

- Access your health programs like personal health record, health decision support and Healthy Lifestyle Coaching.
- Learn how to use your Aetna discounts.

Health decision support from Emmi

Access a library of online learning programs that:

- 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.

Support centers

- **Cancer Support Center.** Get education, tips and tools for breast, colorectal, lung, prostate and women's reproductive cancers.
- **Joint Pain Support Center.** Everyone's experience with joint pain is different. Find information to help you decide the best path for you.
- **Maternity Support Center.** Find resources to help you through each stage of your pregnancy journey.
- **Mental Health Support & Services.** We all need a little support from time to time. Connect with someone, find community support or learn more on your own to feel better, sooner.

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.

Register now to get started

- Visit **Aetna.com** to create an account and log in to your member website.
- Get the Aetna Health app by texting AETNA to 90156 to receive a download link. Message and data rates may apply.*

*Terms and Conditions: aet.na/Terms Privacy Policy: Aetna.com/legal-notices/privacy.html By texting 90156, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna Health app. Consent is not required to download the app. You can also download by going to the Apple® App Store® or Google Play.

Teladoc®

Teladoc can help 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. Teladoc is a convenient and affordable alternative to costly urgent care and emergency room (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. Support is available for you and your covered family members age 13 and over.

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

- $190 for psychiatrist (initial visit)
- $95 for psychiatrist (ongoing visits)
- $85 for psychologist, licensed clinical social worker, counselor or therapist

Skin care

You can also 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 Teladoc account and upload images of your issue. You'll receive a response within two business days. The cost for a consult is $75, which includes a free follow-up visit within seven days.

All other Teladoc consultations are $49. Once you meet your annual deductible, all Teladoc consultations are covered at 100%.

With Teladoc, you can:

- **Resolve many of your medical issues**
  Teladoc doctors 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** or through your member website or Aetna Health℠ app.

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:

- **MDLIVE** provides services to members in all 50 states and the District of Columbia and accepts patients age 10 and older. To register and schedule a session, call **1-855-824-2170** or go to **MDLIVE.com/BHCOMM**.
- **Array AtHome Care** provides services to members who live in California, Delaware, Florida, Illinois, Missouri, New Jersey, New York, Pennsylvania, Texas and Virginia and accepts patients age 5 and older. Call **1-800-442-8938** or go to **ArrayBC.com/patients**.
- **Telemynd** provides services to members who live in all states not covered by Array AtHome Care and accepts patients age 18 and older. Call **1-866-991-2103**.

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 or prostate cancer recovery
- Caregiver status (child, elder, autism)
- Depression or 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.

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 available through your prescription drug plan. Please call Express Scripts at **1-866-713-7779** for more information.

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 laser eye 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 discounts. 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)**.

DISCOUNT OFFERS ARE NOT INSURANCE. They are not benefits under your insurance plan. You get access to discounts off the regular charge on products and services offered by third-party vendors and providers. Aetna makes no payment to the third parties — you are responsible for the full cost. Check any insurance plan benefits you have before using these discount offers, as those benefits may give you lower costs than these discounts.

Digital care for back and joint pain

Through Aetna Back and Joint Care, Hinge Health offers exercise therapy programs designed to address chronic back, knee, hip, neck and shoulder pain. They also offer a downloadable prevention program tailored to you aimed at preventing back and joint pain.

You and your enrolled dependents age 18 and up can enroll at no cost. Plus, participation only takes 45 minutes per week, so it easily fits into your schedule.

What does the program include?

The **Prevention Program** includes:

- Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions delivered through a downloadable app

The **Acute Program** includes:

- Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions delivered through a downloadable app
- Up to six virtual visits with a physical therapist

The **Chronic Pain Program** includes:

- A tablet computer and wearable sensors
- Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions
- One-on-one health coaching to provide motivation and support via text, email or phone
- Interactive education to teach you how to manage your specific condition, treatment options and more

Learn more and apply at **HingeHealth.com/JJ**.

For questions, email **hello@hingehealth.com** or call **1-855-902-2777** from 6 AM to 6 PM PT.

Your personal health record

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. Each time we process a new medical claim — such as a doctor visit or a lab result — it's automatically added to your record.

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

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.

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)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-512-0363 . (Arabic)

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)

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

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 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)

Providers are independent contractors and are not agents of Aetna®. Provider participation may change without notice. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit. Refer to **Aetna.com** for more information about Aetna plans.

Discount vendors and providers are not agents of Aetna and are solely responsible for the products and services they provide. Discount offers are not guaranteed and may be ended at any time. Aetna may get a fee when you buy these discounted products and services. Hearing products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care. Vision care providers are contracted through EyeMed Vision Care. LASIK surgery discounts are offered by the U.S. Laser Network and QualSight. Natural products and services are offered through ChooseHealthy®, a program provided by ChooseHealthy, Inc., which is a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a registered trademark of ASH and is used with permission.

Teladoc® is not available to all members. Teladoc and Teladoc physicians are independent contractors and are not agents of Aetna. Visit **Teladoc.com/Aetna** for a complete description of the limitations of Teladoc services. Teladoc, Teladoc Health and the Teladoc Health logo are registered trademarks of Teladoc Health, Inc.

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 20211, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna.com

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