Jeffrey S. Chiesa
CHIESA, SHAHINIAN & GIANTOMASI PC
105 Eisenhower Parkway
Roseland, NJ 07068
(973) 530-2050
jchiesa@csglaw.com

Counsel for Defendants

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI, on her own behalf and on behalf of all others similarly situated, Plaintiff, v. JOHNSON AND JOHNSON, THE PENSION & BENEFITS COMMITTEE OF JOHNSON AND JOHNSON, PETER FASOLO, WARREN LUTHER, LISA BLAIR DAVIS, and DOES 1-20. Defendants.	Civil Action No.: 3:24-cv-671-ZNQ-RLS **Hon. Zahid N. Quraishi** **Hon. Rukhsanah L. Singh**

NOTICE OF MOTION FOR DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AND STRIKE THE JURY DEMAND

PLEASE TAKE NOTICE that on May 20, 2024, or a date to be selected by the Court, the undersigned attorney for Defendants shall move for an Order dismissing the Complaint and striking the jury demand;

PLEASE TAKE FURTHER NOTICE that in support of this motion, Defendants shall rely upon their Brief in Support of their Motion to Dismiss and Strike the Jury Demand and the Declaration of Jeffrey S. Chiesa and attached exhibits, which are being filed simultaneously herewith;

PLEASE TAKE FURTHER NOTICE that a copy of a proposed form of Order accompanies the motion.

Respectfully submitted,

April 19, 2024

/s/ Jeffrey S. Chiesa

Jeffrey S. Chiesa

CHIESA, SHAHINIAN & GIANTOMASI PC
105 Eisenhower Parkway
Roseland, NJ 07068
(973) 530-2050
jchiesa@csglaw.com

Counsel for Defendants

Jeffrey S. Chiesa
Ronald L. Israel
Kathryn Pearson
CHIESA SHAHINIAN & GIANTOMASI PC
105 Eisenhower Parkway
Roseland, NJ 07068
Telephone: (973) 325-1500
jchiesa@csglaw.com
risrael@csglaw.com
kpearson@csglaw.com

Mark B. Blocker (*pro hac vice*)
Scott D. Stein (*pro hac vice*)
Caroline A. Wong (*pro hac vice*)
SIDLEY AUSTIN LLP
One South Dearborn Street
Chicago, IL 60603
Telephone: (312) 853-7000
mblocker@sidley.com
sstein@sidley.com
caroline.wong@sidley.com

Attorneys for Defendants

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI, on her own behalf and on behalf of all others similarly situated, Plaintiff, v. JOHNSON & JOHNSON, THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, PETER FASOLO, WARREN LUTHER, LISA BLAIR DAVIS, and DOES 1-20, Defendants.	Case No. 3:24-cv-00671 **ORAL ARGUMENT REQUESTED**

BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AND STRIKE THE JURY DEMAND

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes and Regulations

Defendants Johnson & Johnson ("J&J"), the Pension & Benefits Committee of Johnson & Johnson, Peter Fasolo, Warren Luther, and Lisa Blair Davis (together, "Defendants") respectfully submit this brief in support of their motion to dismiss the Class Action Complaint (Dkt. 1, the "Complaint") and strike the jury demand.

INTRODUCTION

Johnson & Johnson is an innovative medicine and medical technology company with more than 130,000 employees worldwide. It proudly offers its employees an industry-leading benefits package, which includes robust medical, retirement, and other benefits ranging from adoption assistance and caregiver leave to mental health programs, military service benefits, and more.

As part of this benefits package, J&J sponsors the Johnson & Johnson Group Health Plan (the "Plan"), an optional benefits program through which J&J provides its employees with medical, dental, vision, and prescription drug coverage. Although employees who participate in the Plan contribute toward the cost of these benefits, J&J covers the vast majority of the costs. In 2022, for example, J&J contributed more than $800 million to the Plan – several multiples more than the total employee contributions. Accordingly, J&J has every incentive to obtain these benefits for low prices.

This case focuses on only one component of the Plan: the prescription drug benefit. The Plan offers generous prescription drug coverage. In general, after a

participant meets her annual deductible, the Plan covers at least 80% of her prescription drug costs, and the participant pays no more than $125 for any prescription – even for specialty prescriptions that would otherwise cost her hundreds or thousands of dollars per fill. To administer the prescription drug component of the Plan, J&J has negotiated a contract with Express Scripts, Inc. ("ESI"), one of the three largest pharmacy benefit managers in the United States. As a pharmacy benefit manager, ESI creates pharmacy networks where plan participants can obtain prescription drugs, negotiates prices for those drugs, and manages the day-to-day operation of prescription drug programs.

Plaintiff began participating in the Plan after she was hired in 2021. She brings this suit under the Employee Retirement Income Security Act of 1974 ("ERISA"). Unlike the typical ERISA plaintiff, however, she does not claim that she was denied any benefits under the Plan. Instead, she asserts a novel theory: In Counts I and II, Plaintiff claims that J&J breached ERISA's duty of prudence by entering into an agreement that allowed ESI to charge excessive prices for certain prescription drugs. In particular, the Complaint focuses on the cost of 42 generic specialty drugs, and alleges that cheaper prices were available through online or neighborhood pharmacies. In Count III, Plaintiff also claims that J&J's Pension & Benefits Committee (the "Committee") violated ERISA by failing to give her a Plan document that she requested. All of the claims should be dismissed.

First, Plaintiff lacks Article III standing to assert the prudence claims. She received all of the benefits she was contractually entitled to receive – that is, prescription drug benefits at the cost and under the terms defined in the Plan documents. Under *Thole v. U.S. Bank, N.A.*, 140 S. Ct. 1615 (2020), she therefore cannot show an injury-in-fact traceable to Defendants' alleged imprudence. Moreover, Plaintiff does not allege that she paid for – or was even prescribed – any of the allegedly overpriced drugs referenced in her Complaint. That is an additional reason why she lacks the concrete personal injury that Article III requires.

Second, the Complaint fails to state a claim. To adequately plead Counts I and II, Plaintiff needs allegations showing that Defendants' process for choosing a pharmacy benefit manager and negotiating drug prices was imprudent. The Complaint has no facts whatsoever about that process, so Plaintiff instead asks the Court to infer imprudence based on the prices of 42 generic specialty drugs – among the thousands of prescription drugs covered by the Plan. But it is not enough to simply point to a fraction of the Plan's covered drugs and claim they were too expensive. Instead, Plaintiff must at least allege that similar plans paid less overall for a comparable prescription drug program. The Complaint does not do that. Plaintiff also does not state a claim as to Count III, because she does not allege a "written request" for documents under 29 U.S.C. § 1024(b)(4).

The Court should also strike the jury demand. Third Circuit authority makes clear that Plaintiff has no right to a jury trial for any of her claims.

FACTUAL BACKGROUND

A. The Plan.

J&J has more than 130,000 employees worldwide who are engaged in the research and development, manufacture, and sale of healthcare products. *See* Compl. ¶ 12. It provides medical, vision, dental, and prescription drug benefits to its employees, retirees, and their family members through the Johnson & Johnson Group Health Plan. *Id.* ¶¶ 12–13; Ex. A, Plan Doc. §§ 1.02–03 & Schedule A.[1]

The Plan is self-funded, which means that instead of paying premiums to an insurance company, J&J bears direct financial responsibility for the cost of Plan benefits, including prescription drug benefits. *See* Compl. ¶¶ 13–14; *see also* Ex. A, Plan Doc. § 4.02. While Plan participants pay monthly premiums for their coverage, as well as deductibles and co-pays, those employee contributions pale in comparison to J&J's contributions. For example, in 2022, J&J paid more than $800 million in Plan costs, while participants contributed approximately $148 million. Compl. ¶ 14; Ex. B, Summary Annual Rpt. at 1. Because J&J bears these

[1] The exhibits attached to this motion are Plan documents, which are judicially noticeable at this stage because "the Complaint expressly references and relies upon the Plan." *Lipani v. Aetna Life Ins. Co.*, 2023 WL 3092197, at *6 (D.N.J. Apr. 26, 2023) (citing *In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997)).

costs, it has every incentive to negotiate the lowest prices it can get for the overall package of benefits covered by the Plan, including prescription drug benefits.

B. The Plan's Prescription Drug Benefit.

Under the Plan, participants are eligible to obtain virtually any prescription drug approved for use in the United States. Ex. C, Summary Plan Description at 6–9. In general, if participants have met their annual deductible and obtain the drug at a network pharmacy, they pay 20% of the cost of the drug, up to a maximum of $125 per prescription for any 30-day supply. *Id.* at 7. Thus, participants generally pay no more than $125 a month for any prescription (and often much less). *See id.* at 6–9. And nothing prohibits participants from paying for prescriptions outside the Plan if they prefer. *See id.*

C. The Role of ESI.

To administer the prescription drug portion of the Plan, J&J has contracted with Express Scripts, Inc., a pharmacy benefit manager ("PBM"). Compl. ¶ 94. ESI provides services to the Plan that J&J would otherwise have to provide on its own, such as negotiating with pharmacies to establish pharmacy networks where participants can obtain prescriptions at an in-network level of benefits and contracting with drug manufacturers to secure rebates. *See id.* ¶ 40. ESI also processes participants' claims: When a participant fills a prescription, ESI pays the

pharmacy for the prescription (minus any co-pay), then later receives payment from the Plan. *See id.* ¶ 41.

The Plan's prescription drug prices are negotiated between J&J and ESI, as is typical between a plan sponsor and a pharmacy benefit manager. *See id.* ¶ 47. As part of these negotiations, plan sponsors and pharmacy benefit managers often negotiate limits on the amount that a plan pays for drugs by category based on a benchmark price, such as the "Average Wholesale Price" ("AWP"). *Id.* ¶ 45. For instance, to use Plaintiff's examples, plan fiduciaries and ESI might negotiate a limit on prices equal to "AWP minus 85%" for all generic drugs, "AWP minus 20%" for all branded drugs, and "AWP minus 15%" for all specialty drugs. *Id.* ¶ 47.

D. Plaintiff's Participation in the Plan.

Plaintiff Ann Lewandowski is a participant in the Plan. She does not allege that she was improperly denied any benefits under the Plan or that she had to pay more than the Plan terms required. In addition, she does not allege that she was prescribed or paid for any of the 42 generic specialty drugs that are the focus of her allegations. *See, e.g.*, *id.* ¶¶ 100–13 (allegations about generic specialty drugs), *id.* ¶¶ 173–86 (allegations about Plaintiff). In fact, the Complaint does not contain a single allegation identifying *any* drug she was prescribed, let alone claiming she overpaid for any such drug.

E. The Complaint.

Plaintiff filed this putative class action in February 2024. The Complaint asserts three claims under ERISA. Counts I and II are duplicative claims for breach of the fiduciary duty of prudence under 29 U.S.C. § 1104(a) and 29 U.S.C. §§ 1132(a)(2)–(3) (ERISA Sections 502(a)(2) and 502(a)(3)), based on Plaintiff's theory that Defendants acted imprudently by purportedly failing to negotiate lower prices for "prescription drugs in general and generic-specialty drugs in particular." Compl. ¶¶ 9, 195–207. Count III is a claim for failure to provide a document that Plaintiff allegedly requested under 29 U.S.C. § 1132(c) (ERISA Section 502(c)). *See* Compl. ¶¶ 208–11. The Complaint demands a trial by jury. *Id.* ¶ 212.

ARGUMENT

I. Plaintiff Lacks Article III Standing for the Fiduciary Duty Claims.

Under Rule 12(b)(1), Plaintiff "bears the burden of meeting the irreducible constitutional minimum of Article III standing" as to each claim in the Complaint. *In re Schering Plough Corp. Intron/Temodar Consumer Class Action*, 678 F.3d 235, 244 (3d Cir. 2012) (quotation marks omitted). To meet this requirement, the Complaint must allege that (i) Plaintiff suffered an "injury in fact" that is (ii) "fairly traceable" to the challenged conduct, and (iii) likely to be "redressed" by a favorable judicial decision. *Id.* Injury-in-fact, the "[f]irst and foremost" of these elements, requires factual allegations showing that Plaintiff's injury is

"concrete and particularized," as well as "actual or imminent, not conjectural or hypothetical." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338–39 (2016). "Concrete" means the injury is "real, and not abstract," and "particularized" means the injury "affect[ed] the plaintiff in a personal and individual way." *Id.* at 339–40.

The Complaint fails to meet these requirements for Counts I and II. The gravamen of those claims is that Defendants acted imprudently by allegedly allowing ESI to charge excessive prices for "prescription drugs in general and generic-specialty drugs in particular." Compl. ¶ 9. But such a claim alleges wasting of the Plan's general assets – not a personal harm to Plaintiff, who does not claim she was denied any benefits to which she is entitled. Plaintiff does not even allege she was prescribed any of the drugs she claims were too expensive. Plaintiff thus cannot show an injury-in-fact traceable to Defendants' alleged imprudence, and the Complaint should be dismissed for lack of Article III standing.

A. Plaintiff Lacks Article III Standing Because She Received All of the Benefits She Was Entitled to Receive Through the Plan.

In *Thole v. U.S. Bank*, the Supreme Court held that an ERISA plan participant lacks standing to challenge fiduciaries' alleged mismanagement of the plan if she received all of the plan benefits to which she was entitled. That holding controls and requires dismissal of the prudence claims. Plaintiff "received all of [her] . . . benefits," has "no concrete stake in this dispute," and "therefore lack[s] Article III standing." *Thole*, 140 S. Ct. at 1622.

Thole involved a defined-benefit retirement plan. *Id.* at 1618. "[A]s its name implies," a defined-benefit plan "consists of a general pool of assets" and is "one where the employee, upon retirement, is entitled to a fixed periodic payment." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439 (1999). In other words, the employer bears the risks associated with managing the plan assets, while participants' benefits are defined in the Plan documents and "will not change, regardless of how well or poorly the plan is managed." *Thole*, 140 S. Ct. at 1620. The plaintiffs in *Thole* claimed that their employer violated ERISA by making imprudent decisions about how to manage their defined-benefit plan's assets. *Id.* at 1618. But even though their employer's decisions allegedly caused the plan to sustain losses, the plaintiffs had been paid all of the benefits they were "legally and contractually entitled to receive" under the terms of the plan, and they "would still receive the exact same monthly benefits" regardless of whether they won or lost the suit. *Id.* at 1618–19. The Court thus held that they failed to allege Article III standing. *Id.* at 1621–22.

Plaintiff here lacks standing for the same reasons. Like a defined-benefit retirement plan, the J&J Plan has a general pool of assets held in a trust. Compl. ¶ 14. Participants' benefits, including prescription drug benefits, are paid from those assets. *Id.* Benefits are "not tied to the value of the plan," but instead are "fixed" by the terms of the Plan documents, which operate "in the nature of a

contract." *Id.* And as Plaintiff acknowledges (Dkt. 38 at 1), she received all of the prescription drug benefits she is "legally and contractually entitled to receive" under the Plan's terms. *Thole*, 140 S. Ct. at 1618. She therefore "lack[s] Article III standing" to challenge alleged mismanagement of the Plan. *Id.* at 1622; *see also, e.g.*, *Perelman v. Perelman*, 793 F.3d 368, 374 (3d Cir. 2015) (holding that "even if the defendants' dealings resulted in a diminution in Plan assets, they are insufficient to confer standing").

Plaintiff's conclusory allegation that Defendants' imprudence caused "higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages" (Compl. ¶¶ 198, 206) is wholly speculative and thus cannot confer standing. The allegation is made solely "on information and belief." *Id.* ¶ 158. The Complaint has no factual allegations about how much Plaintiff paid for premiums, deductibles, co-insurance, or co-pays – much less what those amounts might have been if Defendants had negotiated lower prices for the 42 generic specialty drugs at issue, or otherwise negotiated a different contract with ESI or another pharmacy benefit manager. The allegation is "far too speculative to serve as the basis for a claim of individual loss." *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 457 (3d Cir. 2003) (affirming dismissal of ERISA claims for lack of standing); *see also Lewis v. Gov't Emps. Ins. Co.*, --- F.4th ---, 2024 WL 1611865, at *5 (3d Cir. Apr. 2, 2024) ("Conjecture about how a negotiation might have played out . . . is

not enough" for Article III standing); *Glanton ex. rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125 (9th Cir. 2006) (claims that plan sponsor might have reduced co-payments and deductibles if plan expenses were lower were insufficient for Article III standing).[2]

This Court recently rejected virtually identical allegations and dismissed ERISA claims for lack of Article III standing in *Knudsen v. MetLife Group, Inc.*, 2023 WL 4580406 (D.N.J. July 18, 2023), *appeal pending*, No. 23-2430 (3d Cir.). There, the plaintiffs were participants in a self-funded healthcare plan. *Id.* at *5. They claimed their employer violated ERISA by keeping drug rebates for itself instead of allocating them to the plan, on the theory that "[h]ad the drug rebates been properly allocated, Defendant may have reduced co-pays and co-insurance" paid by participants. *Id.* at *1 (quotation marks omitted). The Court rejected that theory because it was "speculative and conclusory," and it held that the plaintiffs lacked Article III standing because they had "no legal right to the general pool of Plan assets" and did "not contend that they did not receive their promised benefits." *Id.* at *5 (citing *Thole*, 140 S. Ct. at 1620).

[2] Plaintiff also cannot rely on *Grasso v. Katz*, 2023 WL 4615299, at *2 (3d Cir. July 19, 2023), which deemed excessive expenses an injury in a completely different context: an abuse of process claim involving expenses arising from responding to subpoenas.

Other courts are in line with *Knudsen*: participants in self-funded healthcare plans lack Article III standing to bring ERISA claims for alleged mismanagement of the plan if they received all of the benefits they were legally entitled to receive under the plan's terms. *See Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 523–29 (9th Cir. 2023) (plaintiffs lacked standing because they received "a fixed set of benefits as promised in plan documents"); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 858 F. App'x 432, 434 (2d Cir. 2021) (plaintiffs who claimed defendants' conduct resulted in "increased out-of-pocket costs and reduced coverage" had no standing because they "received all of their promised health benefits so far") (brackets omitted); *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857, 861–65 (D. Minn. 2021) ("Like the plaintiffs in *Thole* . . . plaintiffs do not allege that they have submitted claims for healthcare expenses that have been wrongfully denied."). Applying that line of authority here, this case should be dismissed. Plaintiff has no standing to challenge Defendants' negotiations with ESI because she undisputedly received all of the prescription drug benefits that she was "legally and contractually entitled to receive" under the terms of the Plan. *Thole*, 140 S. Ct. at 1618.

B. Plaintiff Does Not Allege that She Paid for Any of the Allegedly Overpriced Drugs.

Even if Article III allowed Plaintiff to pursue claims for benefits beyond what she was entitled to receive under the Plan (it does not), she would still lack

standing for an additional, independent reason: she does not allege that she ever paid for – or was even prescribed – any of the drugs that were allegedly too expensive. *See* Compl. ¶¶ 100–13, 173–86.

It is well-settled that a plaintiff who was unaffected by a defendant's conduct does not have standing to challenge that conduct. Instead, "[o]nly those plaintiffs who have been *concretely harmed*" by a defendant's alleged legal violations have standing. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 427 (2021); *see also, e.g.*, *Huber v. Simon's Agency, Inc.*, 84 F.4th 132, 152 (3d Cir. 2023) ("[R]egardless of whether the defendant violated the law, the plaintiff must establish that she herself suffered a concrete harm.").

Plaintiff lacks standing under that rule. The primary focus of her Complaint is that 42 generic specialty drugs covered under the Plan were too expensive. *See* Compl. ¶¶ 100–13. But she does not allege that she ever purchased, attempted to purchase, or was prescribed any of the drugs that were allegedly overpriced. She therefore "plainly" did not suffer any injury-in-fact traceable to Defendants' alleged imprudence. *Finkelman v. NFL*, 810 F.3d 187, 195 (3d Cir. 2016) (affirming dismissal for lack of Article III standing as "plainly correct" because plaintiff "never purchased" the allegedly overpriced tickets at issue).

Plaintiff's failure to allege that she personally paid purportedly inflated drug costs distinguishes this case from others in which courts have concluded that a

complaint adequately pleaded standing. For instance, in *Sweda v. University of Pennsylvania*, 923 F.3d 320 (3d Cir. 2019), and *Boley v. Universal Health Services, Inc.*, 36 F.4th 124, 131–32 (3d Cir. 2022), the plaintiffs claimed that investment options offered through their 401(k) retirement plans were imprudent because they allegedly underperformed or charged excessive fees. Critically, however, the plaintiffs in those cases had each invested in one or more of the challenged investments. *Boley*, 36 F.4th at 131–32; *see also Sweda*, 923 F.3d at 334 n.10 ("[T]he complaint . . . indicate[s] that the named plaintiffs invested in the underperforming investment options."). Plaintiff makes no comparable allegation here. She does not allege that she was ever prescribed even a single one of the allegedly overpriced drugs that are challenged in the Complaint.[3]

Plaintiff's allegations that she had to pay purportedly inflated premiums, deductibles, co-pays, and co-insurance or received lower wages as a result of Defendants' conduct (Compl. ¶¶ 198, 206) are also insufficient because, as explained above, they are entirely "speculative and conclusory." *Knudsen*, 2023

[3] These cases are also distinguishable because they involved defined *contribution* plans rather than defined-benefit-type plans like those in *Thole* and this case. *Sweda*, 923 F.3d at 324; *Boley*, 36 F.4th at 128. As noted above, the *Thole* and J&J plans provide fixed benefits. The defined contribution plan benefits at issue in *Sweda* and *Boley*, in contrast, reflected the amount of each participant's contributions to her account along with investment gains and losses, the latter two of which depend directly on the performance of the plan investment options chosen by the fiduciaries. *Boley*, 36 F.4th at 128 n.2; *see also Thole*, 140 S. Ct. at 1618.

WL 4580406, at *5; *see also Huber*, 84 F.4th at 152 ("[S]tanding cannot be based on speculative injury."). The Complaint does not offer any non-speculative reason to conclude that employees would have received "a higher salary or additional benefits" if Defendants had been able to negotiate lower prescription drug prices for the Plan. *Horvath*, 333 F.3d at 456–57.

Finally, Plaintiff's other two theories of imprudence fail for similar reasons. The Complaint asserts that Defendants mismanaged the Plan by "agreeing to steer beneficiaries toward Express Scripts' mail-order pharmacy Accredo," Compl. ¶ 122, and "failing to disincentivize the use of high-price branded drugs on the Plan's formulary in favor of lower-priced generics," *id.* ¶ 128. But Plaintiff does not allege that she personally was ever "steered" toward Accredo, or that she ever used a branded drug when a lower-priced generic version was available. She thus lacks Article III standing to assert these theories. *TransUnion*, 594 U.S. at 427–28.

II. The Complaint Fails to State a Plausible Claim Under Rule 12(b)(6).

The Court should also dismiss the Complaint in its entirety because it fails to state a plausible claim for relief.

First, Counts I and II fail to state a claim because the Complaint does not plausibly allege that J&J had an imprudent process for selecting and negotiating with ESI. Plaintiff has no specific factual allegations about that process. Instead, she asks the Court to infer an imprudent process based on the prices of a tiny

subset of generic specialty drugs, out of the thousands of drugs covered by the Plan. Those allegations are insufficient. To state a claim for imprudence, Plaintiff must allege facts showing that the overall package of prescription drugs that J&J negotiated with ESI was excessively expensive relative to a "meaningful benchmark" – that is, relative to a comparable package of prescription drug benefits for other similarly situated healthcare plans. The Complaint fails to do that. Moreover, any notion of an imprudent process is implausible: When fiduciaries of a self-funded healthcare plan select and negotiate with a pharmacy benefit manager, they have every incentive to negotiate the best overall deal for the plan (*i.e.*, for the universe of thousands of drugs covered), taking into account costs as well as qualitative factors, such as drug access and quality of services. That is especially so here, given that J&J bears direct financial responsibility for the vast majority of the Plan's costs.

Second, Count III does not adequately state a disclosure claim under 29 U.S.C. § 1024(b)(4) (ERISA Section 104(b)(4)). The statute requires a plaintiff to submit a "written request" for Plan documents, and the Complaint does not allege that Plaintiff made the requisite form of request.

A. Counts I and II Should Be Dismissed Because Plaintiff Does Not Plausibly Allege that Defendants Had an Imprudent Process for Negotiating Pharmacy Benefit Manager Services.

ERISA's duty of prudence turns on "process rather than the results." *McCaffree Fin. Corp. v. ADP, Inc.*, 2023 WL 2728787, at *13 (D.N.J. Mar. 31, 2023). Thus, to state a prudence claim, Plaintiff's allegations must show that Defendants used an imprudent process in choosing ESI as the Plan's pharmacy benefit manager, and in negotiating with ESI with regard to categories of drug prices and other pharmacy benefit manager services. *See, e.g.*, *id.*

The Complaint contains no allegations concerning the actual process by which the Plan selected or negotiated with ESI. Instead, Plaintiff asks the Court to infer imprudence based solely on the prices of a cherry-picked group of 42 generic specialty drugs, out of the thousands of prescription drugs covered by the Plan. But "to raise an inference of imprudence through price disparity, a plaintiff has the burden to allege a 'meaningful benchmark.'" *Matney v. Barrick Gold of N. Am.*, 80 F.4th 1136, 1148–49 (10th Cir. 2023). She is not entitled to an inference of prudence "simply from the allegation that a cost disparity exists." *Id.*; *see also, e.g.*, *McCaffree*, 2023 WL 2728787, at *14 ("A high fee alone does not mandate a conclusion that . . . fees are excessive.") (citation omitted). In the context of plan services, a meaningful benchmark consists of an apples-to-apples comparison between the cost charged to the challenged plan for a set of services and the cost of

those same services to similarly situated plans, to show that similar plans "received the same services for less." *Krutchen v. Ricoh USA, Inc.*, 2022 WL 16950264, at *3 (E.D. Pa. Nov. 15, 2022), *appeal pending*, No. 23-1928 (3d Cir.); *see also, e.g.*, *Mator v. Wesco Distrib., Inc.*, 2022 WL 3566108, at *3 (W.D. Pa. Aug. 18, 2022) (same), *appeal pending*, No. 22-2552 (3d Cir.); *McCaffree*, 2023 WL 2728787, at *14 ("[A]llegations that include a meaningful benchmark are those that plead similarly situated plans received the same services for less."). "[W]ithout a meaningful benchmark," Plaintiff can "not create[] a plausible inference that the decision-making process itself was flawed." *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 280 (8th Cir. 2022) (emphasis omitted).

Some examples illustrate what constitutes a meaningful benchmark. In *Matney v. Barrick Gold of North America*, the plaintiffs claimed that plan fiduciaries had acted imprudently with respect to fees paid to their plan's recordkeeper, and offered as a benchmark the average recordkeeping fees provided to other plans derived from an industry publication. 80 F.4th at 1143–43. The court, however, rejected the industry publication as a meaningful benchmark because there was no allegation that the comparator plans received similar services or that the figures accurately reflected plan costs. *Id.* at 1157–58. By comparison, in *Sweda v. University of Pennsylvania*, the Third Circuit held that an inference of an imprudent process was warranted when a plan's recordkeeping fees were nearly

$5 million and the plaintiffs alleged that similar plans paid less than $1 million for the same set of services. 923 F.3d at 330; *see also McCaffree*, 2023 WL 2728787, at *14 (discussing *Sweda*).

Here, to provide a meaningful benchmark, Plaintiff must allege not that certain drugs were available at a lower cost, but rather that "similarly situated plans received the same services for less" – that is, paid less for the entirety of a comparable prescription drug program. *McCaffree*, 2023 WL 2728787, at *14. After all, the fiduciaries are acting on behalf of the plan as a whole and its tens of thousands of participants, not a subset of participants interested in specific drugs. But the Complaint contains no allegations even suggesting an appropriate benchmark, focusing instead on a tiny sample of drugs within the much larger prescription drug program. *See, e.g.*, Compl. ¶¶ 3–5, 100–13. Allegations that some drugs might be available for less elsewhere "does not state a claim for breach of fiduciary duty with respect to excessive total plan costs" for prescription drugs. *McCaffree*, 2023 WL 2728787, at *15; *see also, e.g.*, *Albert v. Oshkosh Corp.*, 47 F.4th 570, 582 (7th Cir. 2022) (affirming dismissal of excessive-fee claims because complaint lacked "detailed allegations providing a sound basis for comparison") (quotation marks omitted); *Krutchen*, 2022 WL 16950264, at *3 (similar); *Mator*, 2022 WL 3566108, at *5–8 (similar).

The Complaint includes allegations about the practices of a handful of other companies' health plans, Compl. ¶¶ 160–72, but none of these allegations suggest that any plan pays less than the J&J Plan for the same services. Most of these allegations simply describe measures that other plans took that resulted in cost savings, but without any suggestion that those plans paid less in total or per person than the J&J Plan for prescription drugs as a whole. Moreover, none of these allegations suggest that the measures taken by other companies are ones that are commonly taken among plan fiduciaries; on the contrary, many of the paragraphs reflect entirely unique and different approaches, and none suggest that these other companies' plans had the same coverage, access, or service needs as the J&J Plan. *See, e.g.*, *id.* ¶ 162 (carve-out for generic specialty drugs); *id.* ¶ 163 (use of a pass-through PBM). In short, these allegations fail to provide a meaningful benchmark that would allow this Court to infer that J&J had a defective process for choosing or negotiating with its Plan's PBM.

Finally, Plaintiff also claims that participants may have suffered lost wages, but that theory fails for the additional reason that it impermissibly seeks extracontractual damages. *See Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147–48 (1985) (ERISA Section 502(a)(2) does not permit recovery of extracontractual damages). Plaintiff's theory appears to be that if the costs of the Plan were lower, J&J would have to contribute less money to the Plan, and might

have used those saved funds to increase employees' wages. But the wages that a Plan sponsor pays to its employees are not Plan benefits or paid from Plan assets, making them extracontractual. This is not a case in which an agreement specifically required plan savings to be used to increase wages; here, the notion that savings might be used to increase wages is pure speculation.

Ultimately, Plaintiff's desired inference of imprudence is fundamentally implausible. There is no common-sense reason to believe the J&J Plan's fiduciaries would not try to obtain the best overall deal for the Plan. On the contrary, J&J has every incentive to negotiate the best overall deal for Plan services because J&J bears the majority of the Plan's healthcare expenditures. *Cf. Thole*, 140 S. Ct. at 1621 (employers "are often on the hook for plan shortfalls," so "the last thing a rational employer wants or needs is a mismanaged [benefits] plan"). Consistent with those incentives, the obvious alternative explanation for the fact that some drugs allegedly have high prices is that those prices were simply part of the best overall deal Defendants could negotiate for the drug program as a whole. *See White v. Chevron Corp.*, 752 F. App'x 453, 454–55 (9th Cir. 2018) (affirming dismissal of prudence claim because "[s]omething more is needed, such as facts tending to exclude the possibility that [defendants'] alternative explanation is true"). While Plaintiff need not rule out *every* possible explanation for those

prices, she must do more than arbitrarily select a handful of drugs in a single discrete category. That is simply not enough to raise an inference of imprudence.

B. Count III Should Be Dismissed Because Plaintiff Does Not Allege that She Made a Written Request Under 29 U.S.C. § 1024(b)(4).

In Count III, Plaintiff claims that the Committee violated Section 104(b)(4) of ERISA, which requires plan administrators to furnish copies of certain plan documents "upon written request of any participant or beneficiary." 29 U.S.C. § 1024(b)(4). If the Plan administrator does not respond to such a written request within 30 days, then Section 502(c) and Department of Labor regulations provide that a participant may be entitled to a penalty of no more than $110 per day, with the decision of whether to award any penalty to be determined in the Court's discretion. 29 U.S.C. § 1132(c)(1); 29 C.F.R. § 2575.502c-1; *see also* Compl. ¶ 209. Here, Plaintiff alleges that she requested a single document on December 20, 2023, and while she admits that she received a response less than three weeks later (on January 8, 2024), she claims that she was sent the wrong document. Compl. ¶¶ 176–78.

This tempest-in-a-teapot claim – in which the amount at issue is at most $3,410[4] – should be dismissed because the Complaint does not allege facts

[4] Plaintiff claims to have made her request on December 20, 2023 (Compl. ¶ 176), which means the Plan administrator's deadline to respond was January 19, 2024. Defendants' counsel, on behalf of the Committee, provided the requested document on February 19, 2024, which is 31 days beyond the deadline. Even if the

showing that Plaintiff's request satisfied the statutory requirements to trigger a potential penalty. Given the text of the statute, it is well-settled that a "written request" is an "essential" element of a Section 104(b)(4) claim. *McDonough v. Horizon Blue Cross Blue Shield of N.J., Inc.*, 2011 WL 4455994, at *7 (D.N.J. Sept. 23, 2011) (citing *Kollman v. Hewitt Assoc.*, 487 F.3d 139, 144 (3d Cir. 2007)). Plaintiff does not allege that she made a written request; she instead alleges that she requested the single document at issue via an online portal on the website of a third-party plan administrator, Alight. *See* Compl. ¶¶ 176, 178 ("Plaintiff requested through the Alight online portal established by Defendants that all plan documents, including the 'General/Administrative Information Plan Details' document, be mailed to her. . . . [She] has not received the 'General/Administrative Information Plan Details' document she requested."). This does not plead a "written request" under the statute.

The "bare allegation that Plaintiff[] used an online platform" to make a request is not enough to satisfy the requirement that such a request be in writing. *Bafford v. Northrop Grumman Corp.*, 994 F.3d 1020, 1029–30 (9th Cir. 2021)

Court were to impose the maximum penalty of $110 per day, the total penalty would be $3,410. Moreover, the fact that Plaintiff knows her original request was not proper is confirmed by the fact that her counsel in this case sent a formal, written request for documents – with a subject line that read "Request for Plan Documents under 29 U.S.C. § 1024(b)(4)" – on February 20, 2024, the day after Defendants provided the document, and the Committee provided a response within 30 days of that written request.

(discussing the "written request" requirement under another ERISA provision, 29 U.S.C. § 1025(a)). "[A] typed request" would be enough, *id.* at 1030, but that is not what the Complaint says. *See* Compl. ¶ 176. Plaintiff's failure to "include specific allegations about the manner in which [she] submitted the[] request" warrants dismissal of Count III "on the ground that [she] did not allege a written request." *Bafford*, 994 F.3d at 1030; *see also McDonough*, 2011 WL 4455994, at *7 (dismissing Section 104(b)(4) claim for failure to allege a written request); *Cohen v. Independence Blue Cross*, 820 F. Supp. 2d 594, 608–09 (D.N.J. 2011) (same).

III. The Court Should Strike the Jury Demand Because There Is No Right to a Jury Trial for the Statutory Claims Asserted Here.

If the Court does not dismiss the Complaint in its entirety, the Court should strike the Complaint's demand for a jury trial. The Complaint asserts two class-wide ERISA claims: Count I is brought under Section 502(a)(2) and Count II is brought under Section 502(a)(3). The Third Circuit has squarely held that there is no right to a jury trial under either of these provisions. *Pane v. RCA Corp.*, 868 F.2d 631, 636–37 (3d Cir. 1989) (no right under Section 502(a)(2)); *Cox v. Keystone Carbon Co.*, 861 F.2d 390, 393 (3d Cir. 1988) (no right under Section 502(a)(3)); *accord Kairys v. Southern Pines Trucking, Inc.*, 75 F.4th 153, 159 (3d Cir. 2023) (no right to a jury trial on ERISA claims). District courts applying this case law have reached the same result, holding that there is no right to a jury trial with respect to either of the sections on which Counts I and II are based. *See*

Alexander v. Primerica Holdings, Inc., 819 F. Supp. 1296, 1305, 1311 (D.N.J. 1993) (finding the law so "unwavering" and "clear" that it sanctioned the plaintiffs for their "baseless" and "bad faith" jury request).

In holding that there is no right to a jury trial, the Third Circuit is not alone. On the contrary, every circuit to consider the issue has found that there is no right to a jury trial under either Section 502(a)(2) or 502(a)(3). *See, e.g.*, *Blake v. Unionmutual Stock Life Ins. Co.*, 906 F.2d 1525, 1526 (11th Cir. 1990); *Bair v. General Motors Corp.*, 895 F.2d 1094, 1097 (6th Cir. 1990).[5]

In Count III, the Complaint asserts a claim under Section 502(c), which permits a court – not a jury – to use its discretion to award a statutory penalty for a plan administrator's failure to provide certain documents. 29 U.S.C. § 1132(c)(1). Given the Third Circuit's clear holdings that there is no right to a jury trial for any portion of Section 502(a), and given that Section 502(c) plainly states that the determination of whether to award any penalty should be made by the Court, there is no right to a jury trial under that section either. Indeed, Defendants are unaware of any case holding that there is a right to a jury trial for such claims.

[5] The only circuit in which this is an open question is the Second Circuit. While the Second Circuit has never held that there is a right to a jury trial for ERISA claims, some district courts have read existing Second Circuit decisions to allow for a jury trial in certain instances. *See, e.g.*, *Cunningham v. Cornell Univ.*, 2018 WL 4279466, at *1 (S.D.N.Y. Sept. 6, 2018). But no court outside the Second Circuit has permitted a jury trial for claims under Section 502(a)(2) or (a)(3).

CONCLUSION

For these reasons, Defendants respectfully request that the Court dismiss the Complaint and strike Plaintiff's jury demand.

Dated: April 19, 2024

Respectfully submitted,

/s/ Jeffrey S. Chiesa

Jeffrey S. Chiesa
Ronald L. Israel
Kathryn Pearson
CHIESA SHAHINIAN &
GIANTOMASI PC
105 Eisenhower Parkway
Roseland, NJ 07068
Telephone: (973) 325-1500
jchiesa@csglaw.com
risrael@csglaw.com
kpearson@csglaw.com

Mark B. Blocker (*pro hac vice*)
Scott D. Stein (*pro hac vice*)
Caroline A. Wong (*pro hac vice*)
SIDLEY AUSTIN LLP
One South Dearborn Street
Chicago, IL 60603
Telephone: (312) 853-7000
mblocker@sidley.com
sstein@sidley.com
caroline.wong@sidley.com

Attorneys for Defendants

CHIESA SHAHINIAN & GIANTOMASI PC
105 Eisenhower Parkway
Roseland, NJ 07068
973.325.1500
Jeffrey S. Chiesa, Esq.
Counsel for Defendants

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI, on her own behalf and on behalf of all others similarly situated, Plaintiff, v. JOHNSON AND JOHNSON, THE PENSION & BENEFITS COMMITTEE OF JOHNSON AND JOHNSON, PETER FASOLO, WARREN LUTHER, LISA BLAIR DAVIS, and DOES 1-20. Defendants.	Civil Action No.: 3:24-cv-671-ZNQ-RLS **Hon. Zahid N. Quraishi** **Hon. Rukhsanah L. Singh** **CERTIFICATION OF JEFFREY S. CHIESA IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AND STRIKE THE JURY DEMAND**

JEFFREY S. CHIESA, ESQ., of full age, hereby certifies as follows:

1. I am an attorney-at-law of the State of New Jersey and a member of the law firm of Chiesa Shahinian & Giantomasi PC, attorneys for Johnson & Johnson ("J&J"), the Pension & Benefits Committee of Johnson & Johnson (the "Committee"), Peter Fasolo, Warren Luther, and Lisa Blair (collectively "Defendants") in the above-captioned action. I have personal knowledge of the facts set forth herein.

2. I make this Certification in support of Defendants' Motion to Dismiss the Complaint and Strike the Jury Demand.

3. Attached hereto, and relied upon in the Brief in Support of Defendants' Motion to Dismiss the Complaint and Strike the Jury Demand, are true and accurate copies of the following:

Exhibit A: The Johnson & Johnson Group Health Plan (As Amended and Restated Effective January 1, 2023);

Exhibit B: The 2022 Summary Annual Report for the Johnson & Johnson Group Health Plan;

Exhibit C: A Summary Plan Description entitled "Prescription Drug Coverage Details Supplement" for the Johnson & Johnson Group Health Plan.

4. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

CHIESA SHAHINIAN & GIANTOMASI, P.C.
Counsel for Defendants

By: */s/ Jeffrey S. Chiesa*

Dated: April 19, 2024

Exhibit A

Johnson & Johnson Group Health Plan
(As Amended and Restated Effective January 1, 2023)

CERTIFICATION OF AMENDMENT AND RESTATEMENT
OF THE
JOHNSON & JOHNSON GROUP HEALTH PLAN

Effective as of January 1, 2023, the attached Johnson & Johnson Group Health Plan is hereby amended and restated.

ON BEHALF OF THE
PENSION AND BENEFITS COMMITTEE
OF JOHNSON & JOHNSON

Date: 12/29/22

Douglas Grant
DOUGLAS GRANT
Member

THE JOHNSON & JOHNSON

GROUP HEALTH PLAN

(As Amended and Restated Effective January 1, 2023)

Table of Contents

Page

THE JOHNSON & JOHNSON GROUP HEALTH PLAN
(As Amended and Restated Effective January 1, 2023)

ARTICLE I
NAME, PURPOSE, AND EFFECTIVE DATE

1.01 Name.

This plan is designated as The Johnson & Johnson Group Health Plan (the "Plan").

1.02 Purpose.

The purpose of this Plan is to provide specified health-care related benefits to certain eligible active, former, and retired Employees of Johnson & Johnson and affiliated companies and their Dependents.

1.03 Plan Document.

The official Plan document shall consist of this document (the "Umbrella Plan Document") and the Component Summary Plan Descriptions (SPDs) and Insurance Contracts, each of which is designated on Schedule A hereto and incorporated herein by reference.

1.04 Effective Date.

This amendment and restatement of the Plan is effective as of January 1, 2023.

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.01 Definitions.

The words and phrases used in this document and/or a Component SPD shall have the meanings set forth below, unless otherwise specifically provided or unless a different meaning is required by the context. Any rules set forth in the following definitions shall apply.

(a) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as in effect and as amended from time to time.

(b) **"COBRA Beneficiary"** means any individual who qualifies under COBRA (or state law) for statutory continuation coverage under this Plan solely in accordance with the terms set forth in the applicable Component SPD.

(c) **"Code"** means the Internal Revenue Code of 1986, as in effect and as amended from time to time.

(d) **"Company"** means the Sponsor and the Participating Affiliates.

(e) **"Covered Individual"** means a Participant or a Participant's Dependent who is covered under the Plan.

(f) **"Component SPD"** means a summary plan description that is designated as such on Schedule A hereto. Each Component SPD shall set forth the terms and conditions of one of the component plans that comprise the Johnson & Johnson Group Health Plan, as described elsewhere in this document. Each Component SPD shall specifically define the Eligible Employees to whom that component plan applies and the applicable terms of coverage under that component plan. Each Component SPD shall be deemed to incorporate any materials specifically referenced therein and any applicable Summary of Material Modifications. Each of the Component SPDs is incorporated by reference herein and made a part of the Plan.

(g) **"Dependent"** means any of the following individuals who meets the definition of Dependent as set forth in the applicable Component SPD: (i) the legally married spouse of an Eligible Employee, Former Employee, Retiree, or (if the spouse is not a COBRA Beneficiary), COBRA Beneficiary; (ii) a child of an Eligible Employee, Former Employee, Retiree, (if the child is not a COBRA Beneficiary) COBRA Beneficiary or spousal Surviving Beneficiary; or (iii) a child of a deceased Employee, Former Employee, or Retiree other than the eldest such child. "Dependent" shall also include a "partner" of an Eligible Employee or a child of such partner as set forth in the applicable Component SPD. Partners of Retirees and Former Employees shall not be eligible to participate in the Plan except as specified in the applicable Component SPD.

(h) **"Eligible Employee"** means any Employee who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD. Except as expressly provided in a Component SPD, no "leased employee," as defined in section 414(n) of the Code, or other individual engaged by the Company through a staffing firm or similar entity shall be an Eligible Employee.

(i) **"Eligible Participant"** means an Eligible Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary.

(j) **"Employee"** means an individual who is employed by the Company.

(k) **"Former Employee"** means an individual who has terminated from employment with the Company and who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD. Except as expressly provided in a Component SPD, no "leased employee," as defined in section 414(n) of the Code, or other individual engaged by the Company through a staffing firm or similar entity shall be a Former Employee.

(l) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder.

(m) **"Insurance Contract"** means a contract with one or more of the Insurers which contract may be (i) an insured HMO contract, or other group health insurance or group health coverage contract designated on Schedule A, or (ii) an agreement with respect to one or more Johnson & Johnson Policies and Procedures documents (with Comparison Charts) on Schedule A, between the Sponsor and the Insurer, as amended from time to time, or any successor thereto. The Insurance Contracts are hereby incorporated by reference into, and made a part of, the Plan.

(n) **"Insurer"** means any insurance company that provides group insurance coverage, including a risk-assuming HMO that is identified under "Insurance Contracts" in Schedule A hereto.

(o) **"Participant"** means any individual who is an Eligible Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary who is participating in the Plan in accordance with Article III hereof.

(p) **"Participating Affiliate"** means an Affiliate whose employees have been approved for integration into the Plan by the Sponsor. Such entity shall become a Participating Affiliate as of the date its participation in the Plan begins and shall cease to be a Participating Affiliate on the date as of which it or the Sponsor determines its participation shall terminate. For purposes of clarity and without limitation, any Affiliate identified in Schedule B shall not be a Participating Affiliate. **"Affiliate"** means any entity that, together with the Sponsor, constitutes a group of trades or businesses under common control, a controlled group of corporations, or an affiliated service group as defined in Sections 414(b), (c), and (m) of the Code, respectively, or that must otherwise be aggregated with the

Sponsor under Section 414(o) of the Code. **"Controlled Group"** means the Sponsor and all of its Affiliates.

(q) **"Pension and Benefits Committee"** means the Pension and Benefits Committee of Johnson & Johnson.

(r) **"Plan"** means The Johnson & Johnson Group Health Plan, as herein set forth, and as amended from time to time, together with the attachments hereto and materials incorporated by reference herein and/or, as applicable in context, the relevant component plan, as described in Section 8.13.

(s) **"Plan Administrator"** means the administrator of the Plan, for purposes of the Employee Retirement Income Security Act of 1974, as amended, and the purposes set forth herein, as designated in Section 7.01.

(t) **"Retiree"** means an individual who is retired from employment with the Company and who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD.

(u) **"Service Administrator"** means an organization designated by or contracting with the Sponsor for purposes of providing administrative services under the Plan, as described in Section 7.03.

(v) **"Sponsor"** means Johnson & Johnson, a corporation organized under the laws of the State of New Jersey, which is the sponsor of the Johnson & Johnson Group Health Plan and the component plans that comprise the Johnson & Johnson Group Health Plan for purposes of the Employee Retirement Income Security Act of 1974, as amended, and the purposes set forth in this Plan.

(w) **"Surviving Beneficiary"** means a surviving spouse or, where there is no surviving spouse, the eldest surviving child of a deceased Employee, Former Employee, or Retiree, which spouse or child remains eligible to enroll for coverage in accordance with the terms of the applicable Component SPD. "Surviving Beneficiary" also shall include a surviving partner of a deceased Employee, Former Employee or Retiree, or the eldest surviving child of such partner, as set forth in the applicable Component SPD. To be regarded as a Surviving Beneficiary, a surviving spouse, partner, child or partner's child must actually have the right to make an enrollment election under the Plan and not merely be eligible to be enrolled by another survivor of the deceased Employee, Former Employee, or Retiree.

(x) **"Trust"** means the trust fund or funds established by the Sponsor for purposes of providing the benefits payable under the Plan and any other employee welfare benefit plan that the Sponsor may maintain.

(y) **"Trustee"** means the bank or trust company approved by the Sponsor to be the administrator of the Trust.

(z) **"Trust Fund"** means a fund within the Trust established by the Sponsor for purposes of providing benefits and defraying administrative expenses under the Plan.

(aa) **"Workforce"** means workforce within the meaning of the administrative simplification provisions of the HIPAA, including employees, volunteers, and trainees of the Company; other persons whose conduct, in the performance of work for the Company, is within the direct control of the Company, whether or not they are paid by the Company; and persons who are assigned under a contract to perform a substantial proportion of their activities for the Company at work stations on the Company's premises.

2.02 Gender and Number.

Masculine pronouns shall refer to both males and females. Singular or plural words shall be construed to refer to the plural or singular, respectively, when appropriate.

ARTICLE III
ELIGIBILITY AND COVERAGE

3.01 Eligibility for Participation.

An individual who is an Eligible Participant shall be eligible to become a Participant in the Plan as of the first day on which the individual satisfies the eligibility requirements specified in the applicable Component SPD and, where insured, Insurance Contract. Dependents of an Eligible Participant shall be eligible to participate in accordance with the provisions of the applicable Component SPD. The Component SPDs shall identify the Employees, Former Employees, Retirees, COBRA Beneficiaries and Surviving Beneficiaries who are eligible to participate in the Plan. For purposes of determining the eligibility of any individual for coverage under the Plan, the individual's status as an Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary, leased employee, or any other classification of individuals shall be determined by the Company in accordance with the terms of the applicable Component SPD and the Company's own policies, practices and classifications, regardless of the treatment of the individual for any purpose under the Code, the common law, or any other source of legal authority and regardless of any determination of such status, whether prospective or retroactive, as to the individual's status by any governmental agency or other governmental entity.

The Company may identify additional groups of employees or former employees on a periodic basis that may be added to or deleted from coverage under the Plan. In such event, the Company shall so notify the applicable Service Administrator and shall identify the affected individuals in the applicable Component SPD.

3.02 Benefit Options and Levels of Coverage.

The benefit options and levels of coverage available to Participants under the Plan shall be as set forth in the Component SPDs and, as applicable, Insurance Contracts. The terms and conditions governing each benefit option and level of coverage, including, but not limited to, the form, amount, and duration of benefits, the availability of coverage for Dependents, the coordination of benefits with other group medical plans, the right to pursue inappropriate or excess payments and to pursue fraud, the treatment of qualified medical child support orders, and the amount and payment of any contributions or premiums shall be as set forth in the applicable Component SPD, the materials referenced therein, and, if applicable, the relevant Insurance Contract.

3.03 Procedure for and Effect of Enrolling in the Plan.

An Eligible Participant may enroll in the Plan and become a Participant at the times and in accordance with the procedures established from time to time by the Plan Administrator. Each applicable Component SPD and, as applicable, Insurance Contract shall set forth the procedures for initial enrollment, annual enrollment, and any permitted changes or modifications to coverage for all Eligible Participants and their Dependents, as well as the provision for Dependent eligibility verification. Except as set forth in the applicable Component SPD, a Participant's Dependents may be enrolled only for the same coverage that applies to the Participant. By enrolling in and becoming a Participant in the Plan, each Eligible Participant and his Dependents

shall, for all purposes, be deemed to have assented to the provisions of the Plan and all amendments thereto.

3.04 Termination of Coverage.

A Participant's coverage, including coverage, if any, for Dependents, shall terminate in accordance with the terms of the applicable Component SPD, and, if applicable, with respect to the coverage offered by an Insurer, the relevant Insurance Contract.

3.05 Waiver and Default.

An Eligible Participant may waive coverage under the Plan for himself and/or his Dependents, if any, to the extent permitted by, and in accordance with, the procedures specified in the applicable Component SPD. An Eligible Participant who fails to elect or waive coverage under the Plan for himself and/or his Dependents shall be provided with the default coverage, if any, specified in the applicable Component SPD.

3.06 Limitations.

Notwithstanding any other provision of the Plan, if the Plan Administrator determines at any time that the Plan may fail any nondiscrimination requirement imposed on the Plan by the Code, or any other provisions of applicable law, the Plan Administrator may take such action as is necessary or appropriate, in the judgment of the Plan Administrator, to assure compliance with the applicable requirement. To the extent that coverage is provided under an insured HMO or other insured option, no benefits shall be paid unless they are provided under the applicable Insurance Contract.

ARTICLE IV
CONTRIBUTIONS, FUNDING, AND PAYMENT OF BENEFITS

4.01 Participant Contributions.

The Sponsor shall establish each year the amount of Participant contributions that may be required under the Plan for each benefit option and level of coverage, as well as any other cost-sharing measures that apply, including, but not limited to, deductibles, copayments, coinsurance percentages, out-of-pocket maximums, and lifetime maximums. The amount of any Participant contributions and cost sharing shall be set forth in each applicable Component SPD and/or annual enrollment materials.

Participants may make contributions to such benefits by salary reduction elections under the Sponsor's flexible benefits plan, or by any other method set forth in the applicable Component SPD or prescribed by the Plan Administrator.

4.02 Funding and Establishment of Trust.

Benefits under this Plan shall be funded through contributions made by the Company and by enrolled Participants. All contributions to the Plan by the Company and Participants shall be transferred to one or more Trust Funds that shall be established by the Sponsor or, as the Plan Administrator determines, in its discretion, paid directly as premiums to an Insurer. The Sponsor shall establish one or more Trust Funds with one or more banks or trust companies. The Sponsor shall appoint one or more Trustees with respect to each Trust Fund and may, at its discretion, remove any Trustee appointed by it and appoint as successor any other individual bank or trust company that it determines to have appropriate qualifications.

4.03 Payment of Benefits and Expenses.

a. Insured Benefits. With respect to any benefits that are provided through an Insurance Contract, the Company shall provide for such benefits through the payment of premiums from the Trust Funds (or at the Plan Administrator's discretion from funds not placed in the Trust) to the applicable Insurer, and neither the Company nor the Trust shall have any other liability with respect to such benefits.

b. Self-Insured Benefits. Some or all of the benefits under the Plan may be provided by the Company on a self-insured basis. All self-insured benefits shall be paid by the Company from the Trust Funds in accordance with the terms of the applicable Component SPD.

c. Expenses of the Plan. As directed by the Plan Administrator, the Trustee shall also pay out of the Trust Funds assets expenses of administration of the Plan including fees and expenses of the Service Administrators and expenses of other parties of interest reasonably chargeable to the Plan to the extent permitted by the law. The Plan Administrator may alternatively pay such expenses out of the general assets of the Sponsor

d. Limitation of Benefits. Benefits under the Plan shall be paid to the extent assets are available in the Trust Funds or, as applicable, provided by an Insurer under an Insurance

Contract. The Employer shall not be obligated to pay benefits under the Plan in excess of the amounts available under the Trust Funds or, as applicable, provided through an Insurance Contract.

e. Trust Funds. All contributions to the Trust for the Plan shall be placed in one or more Trust Funds. The Trust Funds shall be maintained and used solely for the payment of benefits and administrative expenses under the Plan. To the extent that the Trust includes funds for the payment of benefits and administrative expenses under other welfare benefit plans, such amounts shall be placed and held in separate funds and shall not be used for purposes of the Plan. Amounts in the Trust Funds shall, at all times, be accounted for separately from any other funds held in the Trust.

4.04 Payment to Participant or Health Care Provider.

Except as otherwise provided in Section 4.05 and 8.12, benefit payments under this Plan shall be made to the Covered Individual or to a health care provider in accordance with the terms of the applicable Component SPD and, as applicable, Insurance Contract**.**

4.05 Incompetence.

If the Plan Administrator determines that a Covered Individual is not competent, benefit payments may be made to the court-appointed legal guardian of the Covered Individual, to an individual who has become the legal guardian of the Covered Individual by operation of state law, or to another individual whom the Plan Administrator determines to be entitled to receive such payments on behalf of the Covered Individual. Such payments shall, to the extent thereof, discharge all liability of the Company.

4.06 No Duplicate Payments/Recovery of Excess Payments.

If a payment of benefits under the Plan is made to a third party whom the Plan Administrator has determined to be entitled to receive such payment on behalf of a Covered Individual, the Plan shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Covered Individual. If a payment of benefits under the Plan is made to a Covered Individual, the Plan shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment on behalf of that Covered Individual to a third party. It is a Covered Individual's responsibility to pay providers for service and supplies that the Covered Individual receives. If any benefit payment is made erroneously, in duplication, or in excess of the amount appropriately payable under a Component SPD or Insurance Contract, the Covered Individual, or the Participant or third party recipient of payment with respect to such Covered Individual shall be responsible for repaying such amount in such manner as the Plan Administrator prescribes.

ARTICLE V
STATUTORY CONTINUATION COVERAGE

5.01 Statutory Continuation Coverage.

Covered Individuals shall be eligible for statutory continuation coverage under the Plan (if at all) solely in accordance with the terms set forth in the applicable Component SPD. With respect to insured coverage only, a Covered Individual's right, if any, to convert to individual coverage shall be determined by the terms of the applicable Insurance Contract. No conversion rights are available under the Plan with respect to any self-insured coverage.

ARTICLE VI
CLAIMS AND APPEALS

6.01 Procedures for Claims and Appeals.

To be entitled to payment of any benefits under the Plan, a Covered Individual must submit all claims for benefits under the Plan and all appeals of claims that have been denied to the appropriate Service Administrator in accordance with the procedures established by the Sponsor and set forth in the applicable Component SPD or Insurance Contract.

6.02 Limitations on Legal Action.

A Covered Individual must pursue all claim and appeal rights available under the Plan (other than any voluntary appeals) before seeking any other legal recourse. Any legal action under the Plan with respect to a denied claim must be initiated within one year of the date that the final appeal is denied or, if shorter, within the applicable statute of limitations.

ARTICLE VII
ADMINISTRATION

7.01 Plan Administrator.

The Pension and Benefits Committee shall administer the Plan and shall be the named fiduciary and Plan Administrator. The Plan Administrator may delegate any of its or other's fiduciary or administrative responsibilities (other than the responsibility of Trustee) to other fiduciaries and administrators. The Plan Administrator may allocate any such fiduciary responsibility, which shall be exercisable severally and not jointly with each named fiduciary's responsibilities being limited to the specific area of responsibility set forth below, or as the Plan Administrator may further allocate and may (i) designate persons or entities other than named fiduciaries to carry out fiduciary and administrative responsibilities (other than Trustee's responsibilities) under the Plan; (ii) employ or contract with one or more persons or entities to render advice and counsel with respect to any responsibility under the Plan; and (iii) engage an independent public accountant on behalf of the Participants to conduct an annual examination of the books and records of the Company in respect of the Plan and on the basis of such examination make such report as the fiduciaries severally request. When acting on the Plan or Plan Administrator's behalf, the Sponsor may also delegate and allocate the Plan Administrator's responsibilities with the same effect as the Plan Administrator's delegation and allocation of such responsibilities. Any person or group of persons (except Trustees) may serve in more than one fiduciary capacity or administrative capacity with respect to the Plan. To the extent permitted by the Plan Administrator, any fiduciary under the Plan, other than the Plan Administrator, may delegate and allocate its responsibility.

Any action by the Plan Administrator assigning any of the Plan Administrator's responsibilities to persons who are all members of the Pension and Benefits Committee or the Company's Workforce shall not constitute an allocation of the Plan Administrator's responsibility but rather shall be treated as the manner in which the Plan Administrator has determined to discharge its responsibilities with respect to the Plan.

To the extent that any of the Plan Administrator's responsibilities have been delegated, to a Service Administrator under Section 7.03 or otherwise, references in the Plan to "Plan Administrator" shall be deemed to refer to the designee who has been delegated such responsibilities.

7.02 Trustee.

The Trustee shall have the authority under the Plan (i) to receive contributions, (ii) hold, manage, invest, and reinvest Plan funds, to the extent responsibility is not retained by the Plan or assigned to an investment manager (which powers may be so retained or assigned notwithstanding anything in Section 7.01), and (iii) upon appropriate direction pay out funds for claims and expenses.

7.03 Service Administrator.

The Sponsor, acting on its own behalf and/or on behalf of the Plan and Plan Administrator, may designate or contract with one or more Service Administrators for the performance of

administrative responsibilities with respect to the Plan, including, without limitation, claims processing and benefit payment, medical (including mental health/substance abuse) case management, disease management, network management, utilization management, utilization review, precertification, and other administrative services for the Plan. A Service Administrator may have responsibility for only components of the above services.

7.04 Discretionary Authority.

In carrying out their respective responsibilities under the Plan, the Plan Administrator, any Service Administrator and other Plan fiduciaries shall have discretionary authority to (i) interpret the terms of the Plan, including the power to remedy possible ambiguities, inconsistencies, or omissions; (ii) determine eligibility for benefits pursuant to the terms of the Plan, as well as the benefits to be provided, including the amount of such benefits; (iii) make any factual determinations; (iv) adopt rules for the administration of the Plan; and (v) take any other actions necessary or appropriate for the effective administration of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be conclusive and be given full force and effect, subject to any right to appeal the interpretation or determination as set forth in the applicable Component SPD or Insurance Contract. No determination of the Plan Administrator, any Service Administrator or other Plan fiduciary in one case shall create a bias or retroactive adjustment in any other case.

7.05 Records of Administration.

Records of administration of the Plan shall be kept, and Participants may ordinarily examine records pertaining directly to them. Records shall be made available in all circumstances required by applicable law, but may be withheld when prepared in anticipation of litigation and in other circumstances as permitted by applicable law.

7.06 Limitation of Liability.

Neither the Plan Administrator nor the Company or any member of its Workforce shall be liable for any loss due to its (or his or her) error or omission in administration of the Plan unless the loss is due to the failure of the Plan Administrator, the Company, or such member of the Workforce to exercise the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

7.07 Indemnification.

The Company shall indemnify each officer, director, employee or other member of the Workforce of the Company for all expenses (other than amounts paid in settlement to which the Company does not consent) reasonably incurred by him in connection with any action to which he may be party by reason of his performance of administrative functions and duties under the Plan, except in reaction to matters as to which he shall be adjudged in such action to be personally guilty of willful misconduct in the performance of his duties. The foregoing rights to indemnification shall be in addition to such other rights as the individual may enjoy as a matter of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the individual may be entitled pursuant to the Sponsor's by-laws.

ARTICLE VIII
GENERAL PROVISIONS

8.01 Amendment and Termination.

The Sponsor reserves the right to amend, modify, revoke, or terminate the Plan, in whole or in part, at any time with respect to any individual or group covered by the Plan, including without limitation any current or future retirees. Any such amendment, modification, revocation, or termination of the Plan shall be made by or pursuant to a written resolution adopted by the Pension and Benefits Committee or by such other means as the Pension and Benefits Committee deems appropriate.

The provisions of the Plan shall be interpreted to comply with applicable requirements of law and, in the event of any change in law, shall be deemed amended to the extent necessary to comply with such change, pending any actual amendment of the Plan for compliance.

In the event the Plan is terminated or changed to exclude a specific group of Eligible Participants and/or their Dependents, the Plan shall pay any claims incurred by a Covered Individual in the affected group before the date of such termination or exclusion to the extent that the Plan provides and to the extent that assets held by the Trust Funds are available (or an applicable Insurance Contract remains in effect). Covered Individuals affected by the termination or exclusion must submit any claims within a reasonable amount of time as determined by the Service Administrator, which shall, in no event be later than the last day for submitting such claims, as specified in the applicable Component SPD or Insurance Contract. The Plan shall not pay any claims incurred on or after the date of Plan termination or exclusion.

8.02 Effect of Plan on Employment.

The Plan shall not be deemed to constitute a contract of employment between the Company and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Participant or Employee at any time regardless of the effect that such discharge may have upon him as a Participant in this Plan.

8.03 Provision of Information.

A Covered Individual may be required to submit proof of other coverage, information pertaining to an individual's status as a Dependent, documentation relating to a claim for benefits, and other information necessary for the proper administration of the Plan as the Plan Administrator may require and direct.

8.04 Protected Health Information.

The Plan shall be subject to the applicable requirements relating to the use and disclosure of "protected health information" imposed by HIPAA and to the rules for certain uses and disclosures of protected health information, all as set forth in the HIPAA Appendix to the Plan, which is incorporated herein by reference.

8.05 Applicable Law.

The Plan shall be governed and administered in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and other federal laws and, to the extent not preempted thereby, in accordance with the laws of the State of New Jersey.

To the extent that some benefits under the Plan are provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by and administered under ERISA and any other applicable federal laws, and, to the extent not preempted thereby, under such state law as is applicable to the Insurance Contract.

Although coverage and benefits under the Plan are, in most circumstances, intended to be excluded from income for federal income tax purposes, there is no commitment or guarantee that any exclusion for any tax or withholding requirement will apply. By enrolling in the Plan, a Participant agrees to be liable for any tax that may be unpaid with respect to coverage or benefits hereunder and any interest or penalties that may be assessed in connection with the tax.

8.06 Responsibilities of Covered Individuals.

Each Covered Individual shall be responsible for providing the Company or such other entity as the Sponsor may identify with his current address. Any notices required or permitted to be given to a Covered Individual shall be deemed given if sent to the address most recently provided by the Covered Individual and mailed by first class United States mail or by such electronic delivery as may be permitted by applicable law.

8.07 Lost Distributees.

Any benefit payable hereunder shall be deemed forfeited if the Plan is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit within the time period set forth in the applicable Component SPD.

8.08 Severability.

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

8.09 Scope of Plan.

The Plan provides solely for the payment of certain health care benefit expenses. All decisions regarding care shall be made by the Covered Individual in consultation with his health care provider.

8.10 Heirs and Assigns.

This Plan shall be binding upon the heirs, executors, administrators, successors, and assigns of all parties, including each Participant and covered Dependent.

8.11 Adopted Children.

Notwithstanding any other provision in the Plan to the contrary, in determining whether any child is a Dependent, a child adopted by an Eligible Participant or placed with an Eligible Participant for adoption shall be treated as a Dependent of such Eligible Participant to the same extent as would a child who is a natural child of such Eligible Participant (without regard to whether the adoption has become final).

8.12 Coordination With State Plans.

The provisions of this Section 8.12 shall apply, notwithstanding any other provision of the Plan to the contrary. The term "State Plan", appearing below, shall mean a plan of any State for medical assistance approved under title XIX of the Social Security Act. The term "State", as used in this Section 8.12, shall have the meaning assigned to such term under section 3(10) of ERISA.

a. Certain Assignments of Rights. The payment of any benefit with respect to a Participant or Dependent under the Plan shall be made in accordance with the terms of any assignment of the rights to such benefit made by, or on behalf of, such Participant or Dependent as required by a State Plan pursuant to section 1912(a)(1)(A) of the Social Security Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

b. Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility. In enrolling an individual as a Participant or Dependent under the Plan, or in determining whether a benefit payment is to be made, or in making a benefit payment to an individual who is a Participant or Dependent, the fact that such individual is eligible for, or is provided, medical assistance under a State Plan shall not be taken into account.

c. Acquisition by States of Rights of Third Parties. To the extent that any payment for medical assistance has been made under a State Plan, in any case in which the Plan has a legal liability to make a benefit payment for items or services constituting medical assistance, the Plan shall make such benefit payment in accordance with the law of any State which provides that the State has acquired the rights of a Participant to such benefit payment for such items or services.

8.13 Component Plans.

This Umbrella Plan Document sets forth terms that apply to various different benefit arrangements described by each of the Component SPDs and Insurance Contracts. The Plan shall be a single plan under this Umbrella Plan Document, for governmental reporting purposes, as applicable to the benefits hereunder, and for other purposes provided that each of the benefits described by a Component SPD shall be administered separately and shall be regarded as a separate plan for purposes of COBRA, certain nondiscrimination testing, the application of exceptions, and certain other purposes under federal law. In that regard, references to the "Plan" throughout this Umbrella Plan Document may refer to the benefits described in a Component SPD instead of or in addition to all of the benefits described in this Johnson & Johnson Group Health Plan.

8.14 No Assignment.

No benefits under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (collectively, "Assignment") by any person, and any attempt to effect such an Assignment by a Covered Individual or any other person shall be void. The Plan has no obligation to accept any direction from a Covered Individual to make payment to any person, and any payment of benefits under the Plan that is made directly to a health care provider or its agent or representative will be made as a convenience to the Covered Individual and not pursuant to or as constituting an Assignment. All benefits under the Plan shall, to the extent permitted by law, be exempt from the claims of creditors and from all orders, garnishments, executions, and other legal process or proceedings.

8.15 Headings and Captions.

The headings and captions set forth in the Plan are provided for convenience only and shall not limit or extend the meanings of any of the Plan's provisions.

SCHEDULE A

Johnson & Johnson

2023 COMPONENT SPDs AND INSURANCE CONTRACTS

The following is a list of Component SPDs and Insurance Contracts as of January 1, 2023. To the extent that the Sponsor adds any Component SPD or enters into an Insurance Contract under the Plan after that date, it will be deemed incorporated into this Schedule A. To the extent that a Component SPD or an Insurance Contract listed or deemed to be listed below is terminated, it shall be deemed deleted from this Schedule A.

COMPONENT SPDs:

1. General/Administrative Information Plan Details
2. Medical Plan Details
3. Premier HSA Plan Details Supplement
4. HRA Plan Details Supplement
5. Dental Plan Details
6. Vision Care Plan Details
7. Salaried Retiree Vision Plan Details
8. Aetna HMO Plan Details Supplement
9. Harvard-Pilgrim Health Plan HMO Plan Details Supplement
10. Separation Medical Plan Summary Plan Description
11. Salaried Retiree Medical Plan Summary Plan Description Pre-April 1, 1985 Retirees
12. Salaried Retiree Medical Plan Summary Plan Description Post-85
13. Salaried Retiree Dental Program SPD
14. Tobacco Cessation Program Plan Details
15. Prescription Drug Coverage Plan Details Supplement
16. Group PPO Plan Details Supplement

INSURANCE CONTRACTS:

1. Cigna Global (including Dental)
2. HMSA PPO
3. Kaiser of California HMO
4. UnitedHealthcare Insurance Company (Medicare Advantage)
5. Aetna DMO
6. Aetna Retiree Dental

SCHEDULE B

AFFILIATES OF SPONSOR DECLINING COVERAGE

Each Affiliate that is part of the Controlled Group's consumer health care business (i.e., Kenvue Inc. and its affiliates that are part of the consumer health care business, collectively, "Kenvue") shall no longer be a Participating Affiliate as of January 1, 2023, and no employee of Kenvue shall be an Eligible Employee as of such date or, if later, as of such date on which the individual becomes an employee of Kenvue. Except as provided in this Appendix*, no Affiliate that is a "participating affiliate" under the Kenvue Inc. Group Health Plan shall be a Participating Affiliate under this Plan, and no individual who is eligible to participate in the Kenvue Inc. Group Health Plan as an employee of Kenvue shall be an Eligible Employee under this Plan.

No employee whose employment is based on employment with an Affiliate in Puerto Rico shall be an Eligible Employee under this Plan.

*During 2023: (i) employees of Affiliates that are part of Kenvue who enrolled for health benefits as of January 1, 2023 in the Harvard Pilgrim Health Plan ("HPHP Option") shall be covered under the HPHP Option under and in accordance with the terms of this Plan. For purposes of clarity, if and when their employer ceases to be an Affiliate, the coverage provided to such individuals under the HPHP Option will be on account of their status as former employees.

Exhibit B

2022 Summary Annual Report

Johnson&Johnson

Summary Annual Report of Your Benefit Plans

This is a summary of the detailed annual financial report for **salaried, certain non-union and union hourly benefit plan participants of Johnson & Johnson** that the Company, as administrator of your benefit plans, files with the federal government. This information is for the period January 1, 2022 through December 31, 2022. The Johnson & Johnson Employer Identification Number (EIN) is 22-1024240.

This annual report has been filed with the Employee Benefit Security Administration as required under the Employee Retirement Income Security Act of 1974 (ERISA).

All Plan participants receive this summary annually. We recommend that you read it and file it with your other benefit plan materials.

Group Health Plan
- Plan No. 501 (the “Plan”)

Basic Financial Statement
Benefits under the Plan are provided by the Company through a Trust Fund, contracts with Health Maintenance Organizations, and a vision and dental vendor, and Administrative Services Agreements with several health care service providers to pay certain health and dental claims incurred under the terms of the Plan.

Plan expenses were $962,050,340. These expenses included $20,353,794 in administrative expenses and $941,696,546 in payments to participants, beneficiaries, and Health Maintenance Organizations.

There were a total of 54,921 participants in or beneficiaries of the Plan at the end of the Plan Year.

The value of Plan assets, after subtracting liabilities of the Plan, was $70,231,757 as of December 31, 2022 compared to $63,595,595 as of January 1, 2022. During the Plan Year, the Plan experienced an increase in its assets of $6,636,162. The financial statements of the Plan are presented on an accrual basis.

The Plan had total income of $968,686,502 including employer contributions of $819,989,553, participant contributions of $148,284,313 and earnings from the Trust of $412,636.

Long-term Disability Income Plan
- Plan No. 504 (the “Plan”)

Basic Financial Statement
Benefits under the Plan are provided through a Trust Fund and Administrative Services Agreements and contracts with service providers to pay Long Term Disability claims incurred under the terms of the Plan.

Plan expenses were $24,787,206. These expenses included $680,539 in administrative expenses, $20,082,619 in premiums for fully-insured benefits, and $4,024,048 in benefit payments to participants.

The value of Plan assets, after subtracting liabilities of the Plan, was $40,001,217 as of December 31, 2022 compared to $54,814,844 as of January 1, 2022. During the Plan Year, the Plan experienced a decrease in its net assets of $14,813,627.

During the Plan Year, the Plan had additions of $9,973,579 including participant contributions of $15,351,106 and a loss from investments of $5,377,527.

Johnson & Johnson Savings Plan
- Plan No. 100 (the “Plan”)

Basic Financial Statement
Benefits under the Plan are provided through a Trust.

Plan expenses were $1,525,547,512. These expenses included $1,480,638,617 in benefits paid or payable to participants and beneficiaries, and $44,908,895 in administrative expenses.

There were a total of 75,241 participants in or beneficiaries of the Plan at the end of the Plan Year.

The value of Plan assets, after subtracting liabilities of the Plan, was $21,190,584,013 as of December 31, 2022 compared to $24,697,532,187 as of January 1, 2022. During the Plan Year, the Plan experienced a decrease in its net assets of $3,506,948,174. This decrease includes depreciation in the value of the Plan assets, that is, the difference between the value of the Plan’s assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year.

The Plan had total income of ($1,981,400,662) including employer contributions of $268,184,717, participant contributions of $759,594,527, and a net depreciation of assets in the amount of ($3,009,179,906).

Group Accident Insurance Plan
- Plan No. 503 (the “Plan”)

Basic Financial Statement
Benefits under the Plan are provided through a Trust Fund and an insurance contract with The Hartford.

Plan expenses were $1,461,158. These expenses included $1,461,158 in insurance premiums paid.

There were a total of 44,757 participants in or beneficiaries of the Plan at the end of the Plan Year.

The value of Plan assets, after subtracting liabilities of the Plan, was $2,490,673 as of December 31, 2022, compared to $2,467,501 as of January 1, 2022. During the Plan Year, the Plan experienced a increase in its assets of $23,172.

The Plan had total income of $1,484,330 including participant contributions of $1,436,242, employer contributions of $24,916 and gain from investments of $23,172.

Insurance Information
The Plan has a contract with The Hartford to pay all Accidental Death and Dismemberment and Permanent Total Disability claims incurred under the terms of the Plan.

The total insurance premiums paid for the Plan Year ending December 31, 2022 under "non-experience-rated" contracts were $1,525,487.

Group Term Life Insurance Plan - Plan No. 502 (the "Plan")

Basic Financial Statement
Benefits under the Plan are provided through a Trust Fund and insurance contracts with Metropolitan Life Insurance Company.

Plan expenses were $19,981,740. These expenses included $19,981,740 in insurance premiums paid.

There were a total of 59,970 participants in or beneficiaries of the Plan at the end of the Plan Year.

The value of Plan assets, after subtracting liabilities of the Plan, was $496,603 as of December 31, 2022 compared to $491,983 as of January 1, 2022. During the Plan Year, the Plan experienced an increase in its assets of $4,620.

The Plan had total income of $19,986,360 including participant contributions of $19,775,789, employer contributions of $205,951 and gain from investments of $4,620.

Insurance Information
The Plan has contracts with Metropolitan Life Insurance Company to pay all life insurance claims incurred under the terms of the Plan. For the portion of "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. The total insurance premiums paid by both employer and participants for the Plan Year ending December 31, 2022 under these contracts were $7,162,174 and the total benefit claims charged under these contracts during the Plan Year were $15,709,310.

For the portion of "non experience-rated" contracts, the total insurance premiums paid by both employer and participants for the Plan Year under these contracts were $26,123,861.

Flexible Benefits Plan - Plan No. 520 (the "Plan")

Benefits included in the Plan are Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account.

Basic Financial Statement – Healthcare Flexible Spending Account
Healthcare Flexible Spending Account is administered by PayFlex. Plan expenses for the year amounted to $3,635,725.40. Participant deposits to the Plan totaled $3,637,341.74. There were a total of 2,158 participants in the program during the Plan Year.

Basic Financial Statement – Dependent Care Flexible Spending Account
Dependent Care Flexible Spending Account is administered by PayFlex. Plan expenses for the year amounted to $11,583,670.81. Participant deposits to the Plan totaled $12,235,640.63. There were a total of 3,332 participants in the program during the Plan Year.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, upon request. The items listed below are included in that report wherever applicable:

1. An accountant's report;
2. Assets held for investment;
3. Transactions in excess of five (5) percent of Plan assets;
4. Insurance information including sales commissions paid by the insurance carriers; and
5. Actuarial information.

To obtain a copy of the full annual report, or any part thereof, write or call the:

Johnson & Johnson Benefit Service Center
Dept 00695
PO Box 64117
The Woodlands, TX 77387-4117
1-800-565-0122

The charge to cover copying costs will be up to $.25 per page for the full annual report or any part thereof. The cost of the full annual report will be determined by its length. In no case will the cost of the full annual report exceed the rate of up to $.25 per page.

You also have the right to receive from the Plan Administrator, upon request and at no charge, a statement of the assets and liabilities of the Plans and accompanying notes, or a statement of income and expenses of the Plans and accompanying notes, or both, wherever applicable. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs will not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the above address, at the main office of the Plan (Johnson & Johnson, 1 Johnson & Johnson Plaza, New Brunswick, NJ 08933), and at the U.S. Department of Labor in Washington, DC, or to obtain a copy from the U.S. Department of Labor upon payment of copying costs.

Requests to the Department of Labor should be addressed to:

Public Disclosure Room, Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Additional Explanation

This Summary Annual Report is intended for all participants who were covered by any of these benefit plans during the Plan Year indicated. Therefore, not all sections apply to everyone. Receipt of this Summary Annual Report, in and of itself, is not indicative of benefits entitlement now or in the future. If you have any questions, please contact the Johnson & Johnson Benefit Service Center.

The benefits provided under your benefit plans are described in various Benefit Plan Summaries. These summaries are updated periodically and can be accessed online by logging on to For Your Benefit (FYB) at: http://digital.alight.com/jnjbsc.

If you experience difficulty with the log on process, or do not have internet access and wish to receive a copy of your benefit plan summaries, please contact the Johnson & Johnson Benefit Service Center for assistance at 1-800-565-0122. Please note that the benefits applicable to specific Plan participants are determined by the effective dates of Plan changes and other Plan membership rules.

This email is intended for internal use only. It is confidential and should not be forwarded or otherwise disclosed beyond the recipients
Do not forward or distribute.

Exhibit C

Summary Plan Description:
Prescription Drug Coverage Details Supplement

PRESCRIPTION DRUG COVERAGE DETAILS SUPPLEMENT

This summary applies to individuals enrolled in one of the following medical options: Premier HSA Plan, HRA Plan, Group PPO Plan and Group Medicare Advantage PPO Plan.

2023 PLAN YEAR

TABLE OF CONTENTS

INTRODUCTION

This summary applies to individuals enrolled in one of the following medical options: Premier HSA Plan, HRA Plan, Group PPO Plan and Group Medicare Advantage PPO Plan. If you are enrolled in one of these medical options under the Salaried Medical Plan or Salaried Retiree Medical Plan, this supplement, when taken together with the following other documents:

For the Salaried Medical Plan:

- General/Administrative Information Plan Details
- Salaried Medical Plan Details
- Premier HSA Plan Details Supplement
- HRA Plan Details Supplement
- Group PPO Plan Details Supplement
- Medicare Advantage Evidence of Coverage (EOC)

Important: If you are an active employee enrolled in an HMO, the description of your prescription drug benefits is provided in the Aetna Self-Funded HMO Plan Details or the Harvard Pilgrim HMO Plan Details available on the *FYB Website*; or for a fully insured HMO, in materials provided to you by the HMO rather than this Prescription Drug Coverage Details Supplement.

For the Salaried Retiree Medical Plan:

- Salaried Retiree Medical Plan for Post-4/1/85 Retirees/Dependents
- Premier HSA Plan Details Supplement
- HRA Plan Details Supplement
- Group PPO Plan Details Supplement
- Medicare Advantage Evidence of Coverage (EOC)

is considered your total Summary Plan Description (SPD) for the Salaried Medical Plan or Salaried Retiree Medical Plan (also referred to in this SPD as the “Plan” or the “Medical Plan”), as required by the Employee Retirement Income Security Act of 1974 (ERISA). Please read these documents carefully and refer to them when you need information about how the Plan works, what the benefits are, what to do in an emergency situation and how to handle service issues. They are also an excellent source for learning about many of the special programs available to you as a participant of the Salaried Medical Plan or the Salaried Retiree Medical Plan.

You will find certain terms starting with capital letters throughout this supplement. To help you understand your benefits, these terms are defined in the “Glossary of Terms” section in the Salaried Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan SPD for Post-4/1/85 Retirees/Dependents) available on the *FYB Website*.

ACCESSING PLAN DETAILS/SUMMARY PLAN DESCRIPTIONS (SPDS) AND FORMS

To access/print Plan Details/SPDs/Medicare Advantage EOC for descriptions of particular benefit Plans, or forms and certain other benefit materials, visit the *For Your Benefit (FYB) Website* at http://fyb.jnj.com.

Alternatively, you can submit a request through the *FYB Website* to have copies of these documents sent to your mailing address on file. You may also call the Benefit Service Center at 1-800-565-0122 (if calling from outside the U.S. or Canada: 1-847-883-0796; TDD: please call your local relay service). You will receive the materials requested within 30 days.

For Your Benefit (FYB)

To access the For Your Benefit (FYB) Website, log on to http://fyb.jnj.com. When you log on you will need to provide your User ID and benefits password (see the box on the next page).

Benefit Service Center

If you have questions as you read through this Supplement, you may contact the Benefit Service Center at the numbers below. When you call, you will need to provide the last four digits of your Social Security number, your birth date and your benefits password (see the box on the next page). The phone numbers below include voice prompts that will connect you directly to the Service Administrators for the Salaried Medical Plan and Salaried Retiree Medical Plan.

To speak with a Benefit Service Representative, call the Benefit Service Center at the applicable number below and say “Representative” at the main menu. Representatives are available Monday through Friday, between 9:00 a.m. and 5:00 p.m., Eastern Time.

1-800-565-0122	Benefit Service Center
1-847-883-0796	For callers outside the United States or Canada
TDD	Please call your local relay service

BENEFIT SERVICE CENTER AUTHENTICATION

You will need your password whenever you call the Benefit Service Center. Instead of your User ID, however, you will enter or say the last four digits of your Social Security number and your date of birth.

To change your User ID or password, visit the *FYB Website* online as described on the preceding page and:

- If you do not remember your User ID and/or password, at the Log On screen, click on "I Forgot My User ID" or "I Forgot My Password."
- If you know your User ID and/or password but want to change it, place your cursor over the "Your Profile" tab, click "Log On Information" and click on "Change."

If you call the Benefit Service Center, say "Password Management" and follow the prompts.

Your new password will be delivered to your mailing address on file within seven business days. You may still call the Benefit Service Center and answer your security questions to authenticate while waiting for your new password.

If you cannot find the answer to your question(s) in the supplement, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section in the Salaried Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan SPD for Post-4/1/85 Retirees/Dependents) available on the *FYB Website*.

This supplement applies only to those individuals described in the Overview And Eligibility section on the next page.

OVERVIEW AND ELIGIBILITY

Prescription drug benefits are administered by Express Scripts as follows:

Express Scripts Prescription Drug Plan For Non-Medicare-Eligible Individuals

This is the prescription drug coverage for:

- Active employees and their covered Dependents enrolled in the Premier HSA Plan, HRA Plan or Group PPO Plan; and
- Eligible Disabled Individuals or retirees and their covered Dependents enrolled in the Premier HSA Plan, HRA Plan or Group PPO Plan who are:
  - Not eligible for Medicare; or
  - Eligible for Medicare but not a citizen of the U.S. or not lawfully present in the U.S.

Express Scripts Medicare® (PDP) For Johnson & Johnson

This is the prescription drug coverage for:

- Eligible Disabled Individuals or retirees and their covered Dependents enrolled in the Premier HSA Plan, HRA Plan, Group PPO Plan or Group Medicare Advantage PPO Plan who are:
  - Eligible for Medicare Part A; and/or
  - Enrolled in Medicare Part B; and
  - A citizen of the U.S. or lawfully present in the U.S.

The Express Scripts Medicare® (PDP) for Johnson & Johnson is a Company-sponsored Medicare Part D prescription drug plan approved by the Centers for Medicare & Medicaid Services (CMS).

NOTE TO ELIGIBLE DISABLED INDIVIDUALS AND RETIREES

For Eligible Disabled Individuals and retirees, the determination of which plan you (Eligible Disabled Individual/retiree or a Dependent) are in is made on an individual basis. Therefore—if you (the Eligible Disabled Individual/retiree) are eligible for Medicare and your Dependent is not, you will be enrolled in the Express Scripts Medicare® (PDP) for Johnson & Johnson—and your Dependent will be enrolled in the Express Scripts prescription drug plan for non-Medicare-eligible individuals. Conversely, if you are not eligible for Medicare but your Dependent is, you will be enrolled in the Express Scripts prescription drug plan for non-Medicare-eligible individuals and your Dependent will be enrolled in the Express Scripts Medicare® (PDP) for Johnson & Johnson.

ID Cards And Contact Numbers

Express Scripts Prescription Drug Plan for Non-Medicare Eligible Individuals

Members will receive 2 ID cards for their family to use with the subscriber name only on the card.

Express Scripts Medicare (PDP) for Johnson & Johnson Medicare

Members will receive their own individual single ID card with their own name on it.

Please note that the Member Services telephone number is different for the non-Medicare versus Medicare plan, as shown below:

Express Scripts Prescription Drug Plan for Non-Medicare-Eligible Individuals: 1-866-713-7779; 24 hours a day, 7 days a week except Thanksgiving and Christmas days.

Express Scripts Medicare® (PDP) for Johnson & Johnson: 1-877-891-1143; 24 hours a day, 7 days a week.

For More Information

For more information about enrolling for prescription drug coverage, when coverage is effective, how to file a claim or an appeal, what happens if you retire, etc., refer to the General/Administrative Information Plan Details and Salaried Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan SPD for Post-4/1/85 Retirees/Dependents) available on the *FYB Website*.

EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN FOR NON-MEDICARE-ELIGIBLE INDIVIDUALS

How The Annual Deductible And Out-of-Pocket Maximum Relate To Prescription Drug Expenses

The medical option you are in determines whether your prescription drug expenses are subject to the medical option's Annual Deductible and/or Out-of-Pocket Maximum, as follows (for more information about the Annual Deductible or Out-of-Pocket Maximum, refer the Premier HSA Plan Details Supplement, HRA Plan Details Supplement or Group PPO Plan Details Supplement available on the *FYB Website*):

Premier HSA Plan

Under the Premier HSA Plan, your Annual Deductible must be met before most prescription drugs will be paid by the plan. Before the Annual Deductible is met, you will be responsible for the full discounted price (at participating retail pharmacies or home delivery) or the full retail price (at non-participating retail pharmacies), and that amount will be applied to the Annual Deductible. Any minimums and maximums (described below) do not apply until the Annual Deductible has been met. Expenses for prescription drugs also count toward the Out-of-Pocket Maximums.

According to IRS guidelines, certain prescription drugs that are used in the treatment of certain conditions can be covered under the Premier HSA Plan bypassing the Annual Deductible. The Premier HSA Plan includes coverage for certain prescription drugs – those on the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list – before you meet the Annual Deductible. This drug list is created by Express Scripts, in accordance with the IRS, and may change from time to time. Find this list on the *FYB Website* or by contacting Express Scripts.

- Drugs manufactured/marketed by the Johnson & Johnson Family of Companies on the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list will be covered at 100%.
- All other drugs on the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list will be covered at the usual prescription drug coinsurance described below.

For all drugs not on the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list, including those manufactured/ marketed by the Johnson & Johnson Family of Companies, you pay the full cost of the drug until you meet the Annual Deductible.

HRA Plan

Under the HRA Plan, prescription drug expenses do not count toward satisfying the Annual Deductible. However, expenses for prescription drugs do count toward the Out-of-Pocket Maximums.

Prescription drug expenses cannot be paid for by your HRA Fund.

Group PPO Plan

Under the Group PPO Plan, prescription drug expenses do not count toward satisfying either the Annual Deductible or the Out-of-Pocket Maximum. However, the Coinsurance amounts for prescription drugs do count toward the prescriptions drug Out-of-Pocket Maximum described below:

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

The prescription drug Out-of-Pocket Maximum under the Group PPO Plan is the most you will need to pay within a Plan Year for your Coinsurance amounts for all prescription drugs purchased through a retail pharmacy or through home delivery.

The individual prescription drug Out-of-Pocket Maximum is $2,000. The family prescription drug Out-of-Pocket Maximum is two times the individual amount, or $4,000. The $4,000 family prescription drug Out-of-Pocket Maximum can be satisfied by any combination of individual prescription drug Out-of-Pocket Maximum amounts. However, no one family member can satisfy more than the stated individual prescription drug Out-of-Pocket Maximum toward meeting the family prescription drug Out-of-Pocket Maximum. Once met, all eligible prescription drug expenses will be paid at 100% of the prescription drug's discounted price if purchased at a participating retail pharmacy or through home delivery or 100% of the retail price if purchased at a non-participating retail pharmacy for the remainder of the Plan Year.

The prescription drug Out-of-Pocket Maximum does not include ineligible expenses and, for prescription drugs purchased at a participating retail pharmacy or through home delivery, amounts that exceed a prescription drug's discounted price.

Filling Prescriptions Through A Retail Pharmacy

Participating Retail Pharmacy

You must present your Express Scripts ID card to the pharmacist to receive In-Network benefits. You pay 20% of a prescription drug's discounted price, up to a maximum of $125 per prescription for up to a 30-day supply. The plan pays 80%, plus any additional cost above your $125 maximum charge. There is a $10 minimum; however, if a drug costs less than $10, you will pay the actual cost.

Reminder: Under the Premier HSA Plan, for most prescription drugs, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list on the *FYB Website*).

Provided you present your Express Scripts ID card at the time of purchase, you do not need to submit a claim form.

To check if your pharmacy is a participating pharmacy, call Member Services at the phone number on your Express Scripts ID card or log on to www.express-scripts.com/jnj.

Non-Participating Retail Pharmacy

You are responsible for 20% of the retail price and the plan will reimburse you 80% of the retail price; however, the plan minimums and maximums do not apply. You will need to pay the pharmacy and submit a claim form for reimbursement. Claim forms and instructions are available on the *FYB Website*.

Reminder: Under the Premier HSA Plan, for most prescription drugs, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list on the *FYB Website*).

Filling Prescriptions Through Home Delivery

If you use the home delivery prescription option for eligible maintenance prescriptions, you pay 15% of a prescription drug's discounted price, up to a maximum of $125 per prescription for up to a 90-day supply. The plan pays 85%, plus any additional cost above your $125 maximum charge. There is a $20 minimum; however, if a drug costs less than $20, you will pay the actual cost of the drug.

Reminder: Under the Premier HSA Plan, for most prescription drugs, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list on the *FYB Website*).

Forms and instructions are available through the *FYB Website* and at www.express-scripts.com/jnj. You can order home delivery prescription refills online at www.express-scripts.com/jnj or by calling Express Scripts at 1-866-713-7779.

Non-Sedating Antihistamines (NSAs) And Proton Pump Inhibitors (PPIs)

For prescription Non-Sedating Antihistamines (NSAs) and prescription Proton Pump Inhibitors (PPIs), you pay 40%, no minimum or maximum, for up to a 30-day supply for participating and non-participating retail pharmacies and up to a 90-day supply for home delivery.

Reminder: Under the Premier HSA Plan, for most prescription drugs, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list on the *FYB Website*).

60% Covered Medications

For certain prescription medications, because of the availability and value of lower cost alternatives you pay 40%, no minimum or maximum, for up to a 30-day supply for participating and non-participating retail pharmacies and up to a 90-day supply for home delivery.

For a list of these medications, please visit the FYB Website or the Express Scripts member website at www.express-scripts.com/jnj.

Reminder: Under the Premier Medical HSA Plan, for most prescription drugs, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under Premier Medical HSA Plan" list on the FYB Website).

Contraceptive Drugs

Prescription contraceptive drugs are covered as follows:

- Prescription generic contraceptive drugs and prescription intravaginal devices purchased at any participating or non-participating retail pharmacy and through home delivery are covered at 100%. Brand contraceptive drugs may be covered at 100% upon review by Express Scripts.
- Contraceptive drugs manufactured/marketed by the Johnson & Johnson Family of Companies and purchased at any retail pharmacy or through home delivery are covered at 100%. Under the Premier HSA Plan, you must first meet your Annual Deductible before the plan will start paying benefits.

Approved Tobacco Cessation Medications And Nicotine Replacement Products

The plan pays 100% for approved prescription and over-the-counter tobacco cessation medications and nicotine replacement products.

Drugs Manufactured/Marketed By The Johnson & Johnson Family Of Companies

The plan pays 100% for drugs that are manufactured or marketed by the Johnson & Johnson Family of Companies; this applies to drugs obtained at any pharmacy or through home delivery. A list of these drugs is available on the *FYB Website* or by calling Member Services at the phone number on your Express Scripts ID card.

Reminder: Under the Premier HSA Plan, for most prescription drugs manufactured/marketed by the Johnson & Johnson Family of Companies, you must first meet your Annual Deductible before the plan will start paying benefits (for exceptions to this, see the "Prescription Drugs that do not require a Deductible under the Premier HSA Plan" list on the *FYB Website*).

Prior Authorization And Drug Quantity Management

Express Scripts also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns. Prescription drugs, unless otherwise stated below, must be Medically Necessary and not experimental/investigational, in order to be covered services. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, establish quantity limits, prior authorizations or other plan limits for specific prescription drugs. Covered services will be limited based on Medical Necessity, quantity limits established by the plan, or utilization guidelines. Please ask your Provider or Network

pharmacist to check with Express Scripts to verify any applicable limits or utilization guidelines.

Specialty Medications: Express Scripts will need to review and approve new prescriptions for certain specialty medications (excluding medications that are manufactured/marketed by the Johnson & Johnson Family of Companies) with your doctor before they can be covered under your prescription drug benefit.

If you or a covered Dependent has a new prescription for a specialty medication, ask your doctor to call Express Scripts at 1-844-374-7377 (24 hours a day, 7 days a week) to arrange for a review of this medication to minimize delays in obtaining the medication at your local pharmacy. Your doctor will need to provide Express Scripts with detailed information to ensure it is being utilized based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

A specialty medication is defined as a drug that is typically used to treat a chronic, complex condition, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis, and has one or more key characteristics, including:

- The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- The need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive specialty pharmacy distribution; and/or
- Specialized product handling and/or administration requirements.

Express Scripts' dedicated specialty pharmacy, Accredo Health Group, Inc., is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs. Whether they're administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medication through Accredo, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24/7
- Expedited, scheduled delivery of your medications at no additional charge
- Necessary supplies, such as needles and syringes, provided with your medications
- Safety checks to help prevent potential drug interactions
- Refill reminders, and
- Health and safety monitoring.

Note: If you or a covered Dependent were prescribed and taking a specialty medication, prior authorization may be required by Express Scripts in the future to continue to be covered.

Compound Medications

Compound medications, by nature, have multiple ingredients. Since they are not regulated by the U.S. Food and Drug Administration (FDA), they can pose serious risks to patients and may not even be effective to treat the diagnosed condition. Therefore, since the FDA does not confirm their quality, safety and effectiveness, compound medications are not covered under the prescription drug plan for non-Medicare-eligible individuals. If your Doctor prescribes a compound medication, ask him or her to prescribe you an FDA-approved medication and contact Express Scripts Customer Service at the phone number on your Express Scripts ID card to make sure the prescription will be covered under your plan.

Miscellaneous Medications

Medications that are non-FDA approved or that offer no therapeutic improvement including compounding kits, pain patches or topical creams/ointments or gels are not covered under the plan.

EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN FOR MEDICARE INDIVIDUALS

The Express Scripts Medicare® (PDP) for Johnson & Johnson does not have the deductible stage that many other Medicare Part D plans have but is required by the Centers for Medicare & Medicaid Services (CMS) to have the other stages that a standard Medicare Part D plan has. These are the: initial coverage stage, coverage gap (informally known as the "donut hole") stage and catastrophic coverage stage. However, because the Company is providing a benefit that provides an enhanced benefit to the standard Medicare Part D benefit – that is, a more generous benefit above and beyond the standard Medicare Part D plan – you will pay the same Coinsurance percentages in the initial coverage and coverage gap stages. Under the Express Scripts Medicare® (PDP) for Johnson & Johnson:

- There is no deductible;
- The Coinsurance percentages that you pay will be the same in the initial coverage and coverage gap stages so you will not experience a coverage gap; and
- If you reach the catastrophic coverage stage (it is reached after your yearly out-of-pocket drug costs [referred to as the True Out-of-Pocket (TrOOP)] reach a certain amount), you will pay a lower Coinsurance percentage for your prescription drugs for the balance of the Plan Year.

Note: Prescription drug expenses do not count toward satisfying either the Annual Deductible or Out-of-Pocket Maximum under your Medical Plan option. There is not a prescription drug Out-of-Pocket Maximum under the Express Scripts Medicare® (PDP) for Johnson & Johnson.

Filling Prescriptions Through A Retail Pharmacy

Participating Retail Pharmacy

If you take your prescription to a participating retail pharmacy and present your Express Scripts Medicare ID card, you will pay 20% of a prescription drug's discounted price, up to a maximum of $125 per prescription for up to a 31-day supply. The plan pays 80%, plus any additional cost above your $125 maximum charge. There is a $10 minimum; however, if a drug costs less than $10, you will pay the actual cost. Provided you present your Express Scripts Medicare ID card at the time of purchase, you do not need to submit a claim form.

To check if your pharmacy is a participating pharmacy, call Customer Service at the phone number on your Express Scripts Medicare ID card or log on to www.Express-Scripts.com/jnj.

Note: Veteran's Administration (VA) pharmacies are not participating pharmacies. If you are eligible for prescription drug coverage through the VA, you can still use that coverage instead of coverage under the Express Scripts Medicare® (PDP) for Johnson & Johnson.

Non-Participating Retail Pharmacy

In an emergency situation, if you take your prescription to a non-participating retail pharmacy, your responsibility will be 20% of a prescription drug's retail price, up to a maximum of $125 per prescription for up to a 31-day supply. However, you will need to pay the full retail price

of the drug at the pharmacy and submit a claim form (available through the *FYB Website* and at www.Express-Scripts.com/jnj) for reimbursement. The plan will reimburse you 80% of the retail cost of the prescription, plus any additional cost above your $125 maximum charge. There is a $10 minimum; however, if a drug costs less than $10, you will pay the actual cost. **Important:** If an emergency does not apply, there will not be any benefit paid for a prescription received at a non-participating retail pharmacy.

Filling Prescriptions Through Home Delivery

If you use the home delivery prescription option for eligible maintenance prescriptions, you pay 15% of a prescription drug's discounted price, up to a maximum of $125 per prescription for up to a 90-day supply. The plan pays 85%, plus any additional cost above your $125 maximum charge. There is a $20 minimum; however, if a drug costs less than $20, you will pay the actual cost of the drug.

Forms and instructions are available through the *FYB Website* and at www.Express-Scripts.com/jnj. You can order home delivery prescription refills online at www.Express-Scripts.com/jnj or by calling Express Scripts at 1-877-891-1143.

Non-Sedating Antihistamines (NSAs) And Proton Pump Inhibitors (PPIs)

Prescription Non-Sedating Antihistamines (NSAs) and prescription Proton Pump Inhibitors (PPIs) are covered at the same Coinsurance levels as other prescription drugs, as described above, depending on where they are purchased.

Contraceptive Drugs

Prescription contraceptive drugs are covered as follows:

- Generic contraceptive drugs purchased at any participating retail pharmacy and through home delivery are covered at 100%. Generic contraceptive drugs purchased at a non-participating retail pharmacy are not considered an 'emergency medication' and therefore would not be covered.
- Contraceptive drugs manufactured/marketed by the Johnson & Johnson Family of Companies and purchased at any retail pharmacy or through home delivery are covered at 100%.

Tobacco Cessation Medications And Nicotine Replacement Products

The plan pays 100% for approved prescription and over-the-counter tobacco cessation medications and nicotine replacement products.

Drugs Manufactured/Marketed By The Johnson & Johnson Family Of Companies

The plan pays 100% for drugs that are manufactured or marketed by the Johnson & Johnson Family of Companies; this applies to drugs obtained at any pharmacy or through home delivery. A list of these drugs is available on the *FYB Website* or by calling Customer Service at the phone number on your Express Scripts Medicare ID card.

Catastrophic Coverage

CATASTROPHIC COVERAGE

Once an individual's out-of-pocket costs in a Plan Year reach the Medicare Part D "true out-of-pocket" limit (TrOOP) – $7,050 for 2022 – the plan pays an enhanced benefit for your prescription drugs (minimum of 95%) for the balance of the Plan Year. TrOOP is the amount you and/or others pay on your behalf during the Plan Year for your prescription drugs, including manufacturer discounts but excluding payments made by the Express Scripts Medicare® (PDP) for Johnson & Johnson.

Medicare Part B Versus Medicare Part D Prescription Drug Determination

Certain drugs may be covered as either a Medicare Part B or Part D drug depending on the reason they were prescribed. Express Scripts will perform a coverage review to determine the appropriate payer (Medicare Part B or Part D) before your pharmacy fills your prescription.

Prior Authorization And Drug Quantity Management

Express Scripts also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns. Prescription drugs, unless otherwise stated below, must be Medically Necessary and not experimental/investigational, in order to be covered services. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits, prior authorizations or other plan limits for specific prescription drugs. Covered services will be limited based on Medical Necessity, quantity limits established by the plan, or utilization guidelines. Please ask your Provider or Network pharmacist to check with Express Scripts to verify any applicable limits or utilization guidelines.

Specialty Medications: Express Scripts will need to review and approve new prescriptions for certain specialty medications (excluding medications that are manufactured/marketed by the Johnson & Johnson Family of Companies) with your doctor before they can be covered under your prescription drug benefit.

If you or a covered Dependent has a new prescription for a specialty medication, ask your doctor to call Express Scripts at 1-844-374-7377 (24 hours a day, 7 days a week) to arrange for a review of this medication to minimize delays in obtaining the medication at your local pharmacy. Your doctor will need to provide Express Scripts with detailed information to ensure it is being utilized based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

A specialty medication is defined as a drug that is typically used to treat a chronic, complex condition, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis, and has one or more key characteristics, including:

- The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- The need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive specialty pharmacy distribution; and/or
- Specialized product handling and/or administration requirements.

Note: If you or a covered Dependent were prescribed and taking a specialty medication prior authorization may be required by Express Scripts in the future to continue to be covered.

Express Scripts' dedicated specialty pharmacy, Accredo Health Group, Inc., is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs. Whether they're administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medication through Accredo, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24/7
- Expedited, scheduled delivery of your medications at no additional charge
- Necessary supplies, such as needles and syringes, provided with your medications
- Safety checks to help prevent potential drug interactions
- Refill reminders, and
- Health and safety monitoring.

Compound Medications

Compound medications, by nature, have multiple ingredients. Since they are not regulated by the U.S. Food and Drug Administration (FDA), they can pose serious risks to patients and may not even be effective to treat the diagnosed condition. Therefore, since the FDA does not confirm their quality, safety and effectiveness, compound medications are not covered under the Express Scripts Medicare® (PDP) for Johnson & Johnson. If your Doctor prescribes a compound medication, ask him or her to prescribe you an FDA-approved medication and contact Express Scripts Customer Service at the phone number on your Express Scripts Medicare ID card to make sure the prescription will be covered under your plan.

Miscellaneous Medications

Medications that are non-FDA approved or that offer no therapeutic improvement including compounding kits, pain patches or topical creams/ointments or gels are not covered under the plan.

Medication Therapy Management (MTM)

This is a free service available to individuals enrolled in the Express Scripts Medicare® (PDP) for Johnson & Johnson. You may be invited to participate in this program which is designed for your specific health and pharmacy needs. The program provides for one-on-one patient consultation with trained staff to help with a patient's self-management of medication. Participation is voluntary, so you may decide not to participate.

Extra Help For Low-Income Individuals

If Medicare identifies you as an individual that qualifies for “Extra Help” to pay for your prescription drug costs, you will receive a letter from Express Scripts informing you of your low-income subsidy level for the year. This financial assistance can take the form of premium reductions and/or enhanced benefits. If you qualify for Extra Help, the Coinsurance percentage you pay for most prescription drugs could range from 0% to 15%, depending on your income level. If you qualify, Express Scripts will advise you of the exact amount of your copay or Coinsurance.

Additional Premium For High Income Individuals

An additional premium for Medicare Part D coverage, called the "income-related monthly adjustment amount" (D-IRMAA), was introduced by the Affordable Care Act (Health Care Reform). If your modified adjusted gross income as reported on your IRS tax return from two years ago is in excess of $85,000 as an individual or $170,000 for a couple filing a joint tax return, you will have to pay extra for your Medicare prescription drug coverage. See the “Additional Premium For High-Income Medicare-Eligible Individuals” in the General/Administrative Information Plan Details (for Eligible Disabled Individuals) or the Salaried Retiree Medical Plan SPD for Retirees/Dependents (for retirees) available on the *FYB Website* for more information.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI, on her own behalf and on behalf of all others similarly situated, Plaintiff, v. JOHNSON AND JOHNSON, THE PENSION & BENEFITS COMMITTEE OF JOHNSON AND JOHNSON, PETER FASOLO, WARREN LUTHER, LISA BLAIR DAVIS, and DOES 1-20. Defendants.	Civil Action No.: 3:24-cv-671-ZNQ-RLS **Hon. Zahid N. Quraishi** **Hon. Rukhsanah L. Singh**

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AND STRIKE THE JURY DEMAND

THIS MATTER having come before the Court upon the motion of Chiesa Shahinian & Giantomasi PC, attorneys for Johnson & Johnson ("J&J"), the Pension & Benefits Committee of Johnson & Johnson (the "Committee"), Peter Fasolo, Warren Luther, and Lisa Blair (collectively, "Defendants"), for an Order granting Defendants' motion to dismiss the Class Action Complaint filed by Plaintiff Ann Lewandowski ("Plaintiff") in its entirety and striking the jury demand contained therein, and on notice to Fairmark Partners, LLP, Wheeler, Diulio & Barnabei, P.C., and Cohen Milstein Sellers & Toll PLLC, attorneys for Plaintiff Ann Lewandowski, and the Court having considered the submissions on behalf of the parties, and the Court having heard the arguments of counsel, and for good cause shown:

IT IS ON THIS _____ day of _____ 2024,

ORDERED that Defendants' Motion to Dismiss the Complaint and Strike the Jury Demand is hereby **GRANTED**; and

ORDERED that all claims against Defendants in Plaintiff's Class Action Complaint are hereby dismissed with prejudice; and it is further

ORDERED that Plaintiff's jury demand is hereby stricken.

Dated: _____

_____
HON. ZAHID N. QURAISHI, U.S.D.J.