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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI and ROBERT GREGORY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Johnson & Johnson Group Health Plan and its component plans, Plaintiffs, v. JOHNSON & JOHNSON and THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, Defendants.	Case No. 3:24-cv-00671-ZNQ-RLS

NOTICE OF DEFENDANTS' MOTION TO DISMISS COUNTS ONE AND TWO OF THE SECOND AMENDED COMPLAINT

PLEASE TAKE NOTICE that on May 19, 2025, or a date to be selected by the Court, the undersigned attorney for Defendants shall move for an Order dismissing Counts One and Two of the Second Amended Complaint;

PLEASE TAKE FURTHER NOTICE that in Support of this Motion, Defendants shall rely upon the Certification of David R. Kott, Esq. and the Brief in Support of Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint submitted with this notice;

PLEASE TAKE FURTHER NOTICE that a proposed form of Order is submitted with this Motion.

Dated: April 22, 2025

Respectfully submitted,

/s/ David R. Kott

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BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS COUNTS ONE AND TWO OF THE SECOND AMENDED COMPLAINT

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INTRODUCTION

After extensive briefing, this Court dismissed the core claims in the First Amended Complaint, finding that Plaintiff Ann Lewandowski lacked standing under Article III to assert them. Since then, another district court has dismissed the same novel ERISA claims, also on standing grounds. *See Navarro v. Wells Fargo & Co.*, No. 24-cv-3043, 2025 WL 897717 (D. Minn. Mar. 24, 2025).

In the Second Amended Complaint, Lewandowski adds allegations contending that by virtue of the actions of a third party, she paid approximately $980—rather than about $770—of the more than $200,000 in medical expenses the J&J Plan paid on her behalf in a single year. She contends that in 2023, a third party reimbursed her for a portion of some of the copayments she made toward her $3,500 out-of-pocket maximum, and that Defendants somehow prevented her from receiving an even greater discount. The Second Amended Complaint also adds a new Plaintiff who complains that he paid $20, rather than the roughly $10 he says he should have been charged, for a single generic drug. But these changes do nothing to cure the standing defects that permeate Plaintiffs' novel theory, and both Plaintiffs lack standing for the reasons articulated in this Court's earlier ruling and in *Navarro*: Their theory of harm depends not on concrete, redressable injury, but instead on layers of speculation about hoped-for changes in healthcare premiums and prices of certain prescription drugs, most of which Plaintiffs do not allege they

ever purchased. Plaintiffs' lack of standing requires the dismissal of Counts One and Two.

Even if Plaintiffs had standing, Counts One and Two, both of which assert claims for breach of fiduciary duty under ERISA, should be dismissed under Rule 12(b)(6). To state these claims, Plaintiffs must adequately plead that Defendants' process for choosing a pharmacy benefit manager and negotiating the cost of the totality of covered drugs was imprudent. At a minimum, this requires allegations that the Plan's *overall* costs—not cherry-picked examples of allegedly overpriced generic drugs, out of the thousands of drugs and healthcare services covered by the Plan—were excessive compared to meaningful benchmarks. But the Second Amended Complaint contains no allegations about Defendants' process, no allegations about the Plan's overall costs, and no allegations of a meaningful benchmark. As a result, even if Plaintiffs have standing, Counts One and Two should be dismissed with prejudice.

BACKGROUND

A. The Plan.

Johnson & Johnson is a medicine and medical technology company with more than 130,000 employees worldwide. Through the Plan, it provides its employees, retirees, and their family members with a generous suite of medical,

vision, dental, and prescription drug benefits. Dkt. 74 (Second Amended Complaint, or "SAC") ¶¶ 14–15; Ex. A, Plan Doc. §§ 1.02–03 & Schedule A.[1]

The Plan is self-funded. Instead of paying premiums to an insurance company, J&J directly bears the lion's share of the costs of medical and prescription drug expenditures on behalf of its employees and retirees. *See* SAC ¶¶ 16–17; Ex. A, Plan Doc. § 4.02. While Plan participants pay premiums, deductibles, and copays, those contributions pale in comparison with J&J's: In 2022, J&J paid more than $800 million in Plan costs, while participants paid just $148 million. *See* SAC ¶¶ 16, 196; Ex. B, Summary Annual Rpt. at 1. Because J&J pays so much of the Plan's costs, it has a strong incentive to negotiate the best deal it can for the overall package of covered benefits, including prescription drugs.

B. The prescription drug benefit.

To meet the needs of different participants, the Plan offers different levels of coverage with different levels of premiums. Each option covers both medical services and prescription drugs, including benefits that allow participants to obtain virtually any prescription drug approved for use in the United States. *See generally, e.g.*, Ex. C, Premier HSA Medical Plan Details Supplement.

[1] The Plan documents (Exhibits A–D) are judicially noticeable because the Second Amended Complaint "expressly references and relies upon the Plan." *Lipani v. Aetna Life Ins. Co.*, 2023 WL 3092197, at *6 n.3 (D.N.J. Apr. 26, 2023).

Under the Premier HSA Medical Plan option—the one chosen by Ms. Lewandowski—a participant must pay a deductible for most covered services. *Id.* at 4. The out-of-pocket costs of medical services and prescription drugs count toward the deductible. *Id.* Applicable law and IRS guidance set floors for the deductibles used by plans like the Premier HSA Plan, and the deductible under J&J's Premier HSA Plan is the lowest permitted by law. Ex. D, Decl. ¶ 6(a).[2]

Once a participant has met her annual deductible, the participant and the Plan split the costs of services, a practice known as "co-insurance." If a participant obtains a drug at an in-network retail pharmacy, she typically pays 20% of the cost of the drug, up to a maximum of $125 per prescription for a 30-day supply. Ex. E, Prescription Drug Coverage Details Supplement at 7. The Plan pays any remaining amount. *Id.* As a result, a participant's responsibility for any given prescription drug is generally capped at $125 a month. *See id.* at 6–9.

The Plan also sets an out-of-pocket maximum that limits the total cost-sharing a participant can bear for in-network services in any given year. *See id.* at 6–7; Ex. C, Premier HSA Medical Plan Details Supplement at 10–11. After a participant meets the deductible and has reached the applicable out-of-pocket maximum for in-network services, the participant pays nothing (and the Plan pays

[2] The Court can consider this declaration for purposes of addressing whether the case should be dismissed under Rule 12(b)(1) for lack of standing. *See, e.g.*, *Sharifi v. Township of E. Windsor*, 2023 WL 2182003, at *3 (D.N.J. Feb. 23, 2023).

the entire amount) for covered expenses, including prescription drugs, for the rest of the year. *See* Ex. C, Premier HSA Medical Plan Details Supplement at 10.

Each year Ms. Lewandowski was a participant (2022–2024), her maximum out-of-pocket amount was $3,500. Ex. D, Decl. ¶ 6(d). Plaintiff Gregory, who retired from J&J in 2020, was eligible for retiree medical coverage and chose coverage for his family with a maximum out-of-pocket amount of $12,000. *Id.* ¶¶ 14(d), 15(d).

C. The role of ESI.

To administer the prescription drug portion of the Plan, J&J contracted with Express Scripts, Inc. ("ESI"), a pharmacy benefit manager ("PBM"). SAC ¶ 94. ESI negotiates drug prices with pharmacies, secures rebates from drug manufacturers, and processes claims for prescription drugs. *See id.* ¶ 38. When a participant obtains a prescription, ESI pays the pharmacy (minus any participant-paid amount), and then later receives payment from the Plan. *See id.* ¶¶ 32–33, 38.

The Plan's drug costs are negotiated between J&J and ESI. *See id.* ¶ 42. As part of these negotiations, plan sponsors and PBMs often negotiate limits on the amount a plan will pay for categories of drugs based on a benchmark price, such as the Average Wholesale Price, or AWP. *Id.* ¶¶ 43–44. To use Plaintiffs' examples, plan fiduciaries and ESI might negotiate prices equal to "AWP minus 85%" for

generic drugs, "AWP minus 20%" for branded drugs, and "AWP minus 15%" for specialty drugs. *Id.* ¶ 45.

D. Plaintiffs' participation in the Plan.

Each year Ms. Lewandowski participated in the Plan, she chose the Premier HSA Medical Plan option. Ex. D, Decl. ¶ 5. Mr. Gregory started participating in the Plan as a retiree in 2020. *Id.* ¶ 12. He selected the Aetna HRA Plan option from 2020 to 2024, then switched to the Aetna PPO Plan option in 2025. *Id.* ¶ 13.

Plaintiffs do not allege that they were denied any benefits under the Plan or that they had to pay more than the Plan terms required. Instead, they claim that two categories of prescription drugs available under the Plan—which are part of the overall package of thousands of health services and drugs the Plan covers—were too expensive. The first category consists of generic "specialty" drugs. *See, e.g.*, SAC ¶ 5. Generally speaking, specialty drugs are used to treat complex or rare conditions, require special handling or care, or historically were available only at hospitals, doctors' offices, or specialty pharmacies. *See id.* ¶ 78. The Second Amended Complaint challenges the prices of 42 such drugs, but Plaintiffs do not allege that they personally were prescribed or paid for any of them. *See, e.g.*, *id.* ¶¶ 99–118, 208–40.

The second category consists of generic "non-specialty" drugs. *See, e.g.*, *id.* ¶ 6. The Second Amended Complaint challenges the prices of 15 such drugs, out of

the thousands of generic non-specialty drugs available through the Plan. It alleges that Ms. Lewandowski was prescribed 14 of these drugs, while Mr. Gregory was prescribed one. *Id.* ¶¶ 126–27, 234–40.

While Ms. Lewandowski and Mr. Gregory allege they overpaid for generic drugs by approximately $210 and $10, respectively, those amounts were dwarfed by the benefits they received. Ms. Lewandowski received approximately $168,000 worth of benefits paid by J&J for 2022, $198,000 for 2023, and $89,000 for 2024. Ex. D, Decl. ¶ 8. Ms. Lewandowski reached the $3,500 maximum out-of-pocket limitation in each year she participated in the Plan, except that in 2023 she allegedly paid only about $980 thanks to a third-party copay assistance card. *Id.* ¶ 7; SAC ¶¶ 217–29. As a retiree, Mr. Gregory has received benefits paid by J&J for himself and his family members worth approximately $10,000 in 2020 (from October through December), $56,000 in 2021, $28,000 in 2022, $107,000 in 2023, $117,000 in 2024, and $14,000 in 2025 (through March). Ex. D, Decl. ¶ 17. In contrast, he has paid approximately $1,200, $8,900, $4,300, $6,300, $5,300, and $1,100, respectively, for benefits in those years. *Id.*

E. The prior dismissal order.

Ms. Lewandowski filed this putative class action in February 2024 and filed a First Amended Complaint in May 2024. Counts One and Two of the First Amended Complaint were essentially identical claims for breach of the fiduciary

duty of prudence under two provisions of ERISA, 29 U.S.C. §§ 1104 and 1132(a)(2)–(3). Both were based on the theory that Defendants failed to negotiate lower prices for certain generic drugs—a small subset of the prescription drugs available through the Plan, and an even smaller subset of healthcare services covered by the Plan. Dkt. 44 ¶¶ 5–6, 230–35.

This Court dismissed both claims for lack of standing. Ms. Lewandowski claimed she was injured because she allegedly paid higher premiums and higher out-of-pocket expenses for prescription drugs. Dkt. 70 ("MTD Order") at 7. The Court held that the "higher premiums" theory was too speculative to show an Article III injury because Ms. Lewandowski provided no "allegation or evidence of premiums on other plans or that Defendants' specific conduct resulted in the higher premiums." *Id.* at 9. The Court also rejected the "out-of-pocket" theory because Ms. Lewandowski "reached her prescription drug cap for each year." *Id.* at 10–11. "Even if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug," the Court said, those funds would be owed to the Plan—not to Ms. Lewandowski—"to reimburse it for its expenditures on *other* drugs that same year." *Id.* at 11. Because the Court dismissed Counts One and Two for lack of standing, it did not reach Defendants' arguments that those claims should be dismissed for failure to state a claim. *Id.*

The Court declined to dismiss Count Three, which involves an alleged failure to comply with ERISA's requirement to provide certain documents to Ms. Lewandowski upon request. *Id.* at 13–15. That claim—asserted on behalf of Ms. Lewandowski only, not a putative class—remains pending and, in deference to this Court's earlier ruling, is not challenged in this motion.

F. The Second Amended Complaint.

The only material changes in the Second Amended Complaint concern Counts One and Two, which still assert that Defendants allowed excessive prices for two categories of prescription drugs. The Second Amended Complaint adds Mr. Gregory as a plaintiff, along with new allegations about premiums, out-of-pocket expenses, and a single additional drug Mr. Gregory purchased. For example, it provides information about Ms. Lewandowski's alleged use of a copay assistance card to meet her maximum out-of-pocket responsibility in 2023, and cites studies unrelated to the Plan purportedly showing that "premiums will increase when plans overspend on prescription drugs." SAC ¶¶ 195, 198–205, 223–29. But the essence of Counts One and Two—and the core legal defects underlying them—remain the same.

ARGUMENT

I. Plaintiffs lack Article III standing to pursue their claims for breach of fiduciary duty.

Plaintiffs must establish standing to pursue each of their claims. MTD Order at 6 (citing *TransUnion v. Ramirez*, 594 U.S. 413, 423 (2021), and *FW/PBS, Inc. v. Dallas*, 493 U.S. 215, 231 (1990)). There are two kinds of challenges to Article III standing: facial and factual. *Mortensen v. First Fed. Sav. & Loan Ass'n*, 549 F.2d 884, 891 (3d Cir. 1977). A facial challenge contests the sufficiency of the pleadings, while a factual challenge, like the one Defendants are asserting here, "concerns the actual failure of a plaintiff's claims to comport factually with the jurisdictional prerequisites" of Article III. *Constitution Party of Pa. v. Aichele*, 757 F.3d 347, 358 (3d Cir. 2014) (quoting *CNA v. United States*, 535 F.3d 132, 139 (3d Cir. 2008) (brackets omitted)). In assessing a factual challenge to standing, courts "review evidence outside the pleadings" and "make factual findings." *CNA*, 535 F.3d at 145.

To meet Article III's standing requirements, Plaintiffs must show that they (i) 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. *In re Schering Plough Corp. Intron/Temodar Consumer Class Action*, 678 F.3d 235, 244 (3d Cir. 2012) (citation omitted); *see also* MTD Order at 6. Injury-in-fact, the "[f]irst and foremost" of these elements, requires a "concrete and particularized"

injury that is "actual or imminent, not conjectural or hypothetical." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338–39 (2016) (citations omitted).

Under *Thole v. U.S. Bank N.A.*, participants in a defined benefit plan where benefits are contractually fixed and "will not change, regardless of how well or poorly the plan is managed," generally lack standing to challenge fiduciaries' management of the plan if they received all of their benefits. 590 U.S. 538, 543 (2020). Plaintiffs do not dispute that they received all of their promised benefits. As a result, they must show that that Defendants caused some other injury. *See* MTD Order at 8–11 (citing *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 573, 578–79 (3d Cir. 2024)). But as explained below, neither their "higher premiums" theory nor their "out-of-pocket" theory supports Article III standing.

A. Plaintiffs' premium allegations do not establish Article III standing.

1. Setting premiums is a non-fiduciary function that cannot support standing for fiduciary claims.

Plaintiffs allege that because annual premiums are based in part on the expected cost of covered healthcare services and drugs, the "excessive" costs of a small fraction of drugs led J&J to set higher premiums in later years for Plan beneficiaries overall. *See, e.g.*, SAC ¶¶ 197–207. But J&J's decision-making on premiums is a non-fiduciary function; it cannot support standing for the fiduciary duty claims.

As relevant here, an entity is a fiduciary only "to the extent" it exercises certain discretionary authority or control over management of a plan. 29 U.S.C. § 1002(21)(A). In other words, "fiduciary status is not an all or nothing concept." *Santomenno v. John Hancock Life Ins. Co. (U.S.A.)*, 2013 WL 3864395, at *4 (D.N.J. July 24, 2013), *aff'd*, 768 F.3d 284 (3d Cir. 2014). The "threshold question" is whether the defendant was "acting as a fiduciary (that is, . . . performing a fiduciary function) when taking the action subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000).

Decisions about plan *design*—like what services to cover, and what portion of those services will be paid by plan participants in the form of premiums—are not fiduciary acts. *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996). Instead, when plan sponsors make decisions about plan design, they are acting in a role "analogous to the settlors of a trust." *Id.* Matters of plan design include decisions about "the form or structure of the Plan," "who is entitled to receive Plan benefits," and "in what amounts." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 444 (1999).

The annual setting of premium amounts is a classic "plan design" decision. *See, e.g.*, *Bator v. Dist. Council 4*, 972 F.3d 924, 932 (7th Cir. 2020) ("setting the contribution rates" is a settlor function); *Hannan v. Hartford Fin. Servs., Inc.*, 2016 WL 1254195, at *2–3 (D. Conn. Mar. 29, 2016) (defendant was "not a fiduciary with respect to negotiation of the Plan premiums"), *aff'd*, 688 F. App'x 85 (2d Cir.

2017); *Argay v. Nat'l Grid USA Serv. Co.*, 503 F. App'x 40, 42 (2d Cir. 2012) ("Defendants did not act in a fiduciary capacity in setting premiums"). When a plan sponsor sets healthcare premiums, it is deciding "the terms of a plan" and "in what amounts" to provide benefits. *Hughes*, 525 U.S. at 444–45. ERISA imposes no obligation to set premiums at any particular level, or to pass along any savings in healthcare expenditures in one year in the form of premium reductions in subsequent years.

Because setting premiums is a non-fiduciary function, Plaintiffs cannot base standing for their fiduciary claims on allegedly higher premiums. That was one reason the analogous claims in *Navarro* were dismissed. The plaintiffs in *Navarro* claimed they had standing because they overpaid for prescription drugs, which in turn allegedly prompted their employer to raise premiums. 2025 WL 897717, at *5, *9. The court rejected this domino theory of harm because the plan gave the defendant "sole discretion" to set premiums. *Id.* at *9. The same is true of the J&J Plan. *See* Ex. A, Plan Doc. § 4.01 ("The Sponsor shall establish each year the amount of Participant contributions . . ."); *see also* SAC ¶ 194; Ex. D, Decl. ¶ 2.

2. The "higher premiums" theory is speculative.

Plaintiffs' "higher premiums" theory cannot create Article III standing for an additional reason: It is speculative. This Court held as much in dismissing the prior

complaint, MTD Order at 9, and the Second Amended Complaint does not fix this deficiency.

Plaintiffs assume that lower costs for 57 of the thousands of prescription drugs covered by the Plan would have led to lower premiums for the Plan as a whole in subsequent years, but this is conjecture. Many factors beyond the costs of a handful of drugs—administrative expenses, non-drug medical costs, the costs of other prescription drugs and categories of drugs, and non-cost factors, to take a few examples—can influence the amount of premiums set each year. *See Navarro*, 2025 WL 897717, at *9 (listing factors "having nothing to do with prescription drug benefits," such as "whether a participant obtains coverage for her spouse or children in addition to herself"); Ex. D, Decl. ¶ 2. No agreement or formula governs the setting of premiums, which are set each year by a company committee. Ex. D, Decl. ¶¶ 2–3. Plaintiffs allege that J&J's premiums were set at a "consistent ratio" of projected costs, SAC ¶¶ 196–97, but their own graph shows that premiums were *not* set at a consistent ratio of projected costs; premiums as a percentage of costs varied over time. *Id.* ¶ 196.

Even if Plaintiffs' allegation were accurate, they would be irrelevant. If Plan costs had been lower, the Plan could have charged the same amounts, and it is speculation to claim otherwise. Ex. A, Plan Doc. § 4.01. As another court noted in dismissing essentially the same ERISA claims, "it is speculative that the allegedly

excessive fees the Plan paid to ESI 'had any effect at all' on Plaintiffs' contribution rates and out-of-pocket costs for prescriptions." *Navarro*, 2025 WL 897717, at *9 (quoting *Knudsen*, 117 F.4th at 582).

Other courts, including the Third Circuit, have rejected similar theories as speculative. For example, in *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450 (3d Cir. 2003), the defendants allegedly caused plaintiff's employer to overpay for health benefits, which allegedly led the employer to provide fewer benefits and lower salaries. *Id.* at 453, 457. The Third Circuit rejected that theory as "too speculative." *Id.* at 457. The theory Plaintiffs propose here is no less speculative. *Accord Navarro*, 2025 WL 897717, at *9.

More recently, in *Knudsen v. MetLife Group, Inc.*, 2023 WL 4580406 (D.N.J. July 18, 2023), *aff'd*, 117 F.4th 570 (3d Cir. 2024), plaintiffs claimed that defendants' fiduciary breaches harmed them by inflating their premiums (and out-of-pocket costs), but the Third Circuit rejected that theory as speculative. *Id.* at *5–6; 117 F.4th at 573, 581–82. The Third Circuit explained that a complaint must plausibly allege that the challenged conduct was the "but-for cause" of higher premiums, such as by alleging "in what years" and "by how much" premiums increased, or how premiums are calculated "under the Plan documents." *Knudsen*, 117 F.4th at 581–82. "Allegations of this sort are necessary" to plead Article III standing, *id.* at 582, but the Second Amended Complaint is entirely devoid of

them. When dismissing the earlier iteration of Counts One and Two, this Court rightly described *Knudsen* as "controlling and dispositive" with respect to the "higher premium" theory. MTD Order at 9.

As in the First Amended Complaint, the allegations in the Second Amended Complaint are indistinguishable from those found wanting in *Knudsen*. Plaintiffs still ignore the many factors that influence premiums, such as non-drug medical costs and the plan sponsor's discretion. *See Knudsen*, 117 F.4th at 582. Plaintiffs reproduce the same graph that appeared in the First Amended Complaint, purportedly (but not actually) showing that premiums mirrored projected costs, and add an allegation that, based on the graph, Defendants expected premiums to equal "17–18% of overall Plan healthcare costs." SAC ¶¶ 195–96. But those allegations provide no more certainty than the allegation in *Knudsen* that premiums were generally set at 30% of projected costs. 117 F.4th at 574. In both cases, the assumption that premiums would have been lower if projected costs had been lower is too speculative to confer standing. *See* MTD Order at 9; *accord Navarro*, 2025 WL 897717, at *9 (applying *Knudsen* and rejecting the same "higher premiums" theory).

Finally, the Second Amended Complaint adds allegations about studies supposedly showing that "employee contributions in the form of premiums will increase when plans overspend on prescription drugs." SAC ¶¶ 198–205. But as

even Plaintiffs admit, this theory requires "holding all else constant," *see id.* ¶ 204—an impossibility given the size of the Plan, the innumerable inputs that affect premiums, and the plan sponsor's discretion to change those premiums. *See* MTD Order at 9 (rejecting speculative assertions about higher premiums under *Finkelman v. NFL*, 810 F.3d 187, 201 (3d Cir. 2016)).

B. Plaintiffs' out-of-pocket cost allegations do not establish standing.

1. The out-of-pocket theory is speculative.

Plaintiffs' second theory of standing is that the alleged fiduciary breaches increased their out-of-pocket costs. SAC ¶ 141. This theory too rests on speculation, as *Navarro* found:

> Plaintiffs' theory of redressability stumbles on the same obstacle: Wells Fargo's "sole discretion" to set participant contribution rates. . . . Simply put, while Plaintiffs' requested relief *could* result in lower contribution rates and out-of-pocket costs, there is no guarantee that it *would*, and "pleadings must be something more than an ingenious academic exercise in the conceivable" to meet the standing threshold.

2025 WL 897717, at *10 (citing *United States v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 688 (1973)). In other words, Plaintiffs' "out-of-pocket" theory of standing ignores the plan sponsor's discretion to set premiums and participant contributions levels, as well as the many factors unrelated to the prices of a few prescription drugs that impact participant out-of-pocket costs. *See id.* at *9 (dismissing complaint for lack of standing because, in relevant part, "it is

speculative that the allegedly excessive fees the Plan paid to ESI" affected "out-of-pocket costs for prescriptions").

As the *Navarro* court explained, "selective allegations regarding the markups on a subset of prescription drugs in the Plan's formulary, which itself represents only a subset of the total benefits whose costs Plan participants' contributions may be used to cover, are not sufficient to establish a causal connection between Plaintiffs' increased costs and ESI's administrative fees." 2025 WL 897717, at *9 (citations omitted). For instance, Ms. Lewandowski alleges that she overpaid a total of $210 on two prescriptions in 2023—in a year when she received Plan benefits with a value of more than $200,000. SAC ¶¶ 141, 218–29; Ex. D, Decl. ¶ 8. Mr. Gregory claims he overpaid about $10 for one drug in 2024—in a year when he received more than $121,000 worth of benefits for himself and his family members. SAC ¶¶ 141, 235–37; Ex. D, Decl. ¶ 17. Under these circumstances, it is speculative to conclude that Defendants' administration of the Plan somehow "harmed" Plaintiffs, including because the Plan may have provided savings on other drugs or medical services Plaintiffs received that outweighed Plaintiffs' modest alleged "overpayments" for certain individual drugs. Because Plaintiffs offer nothing but speculation to "fill in the necessary inferential gaps" to jump from isolated alleged overpayments to an overall increase in out-of-pocket costs, they lack standing. *Knudsen*, 117 F.4th at 582.

2. Ms. Lewandowski's "out-of-pocket" theory fails for additional reasons.

In granting Defendants' prior motion to dismiss, the Court ruled that Ms. Lewandowski's alleged out-of-pocket injury is not redressable because she met her $3,500 maximum out-of-pocket limit each year she participated in the Plan. As a result, "[e]ven if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug," those funds would be owed to the Plan "to reimburse it for its expenditures on *other* drugs that same year." MTD Order at 11. Ms. Lewandowski has amended her allegations in an effort to address this deficiency by arguing, oddly, that the fact that she received hundreds of thousands of dollars in benefits while managing to pay only about $980 out of pocket in 2023—far less than the $3,500 cap—caused her injury. But her allegations still fail to show Article III standing, for three reasons.

First, the Second Amended Complaint asserts that notwithstanding the $3,500 out-of-pocket limit, Ms. Lewandowski actually paid only "$979.57 in out-of-pocket [expenses] in 2023" thanks to a copay assistance card—a discount provided by a third-party drug manufacturer. SAC ¶¶ 228–29. She claims that but for Defendants' challenged conduct, she would have paid only $769.57 ($210 less) given the way the copay assistance card worked. *Id.* ¶¶ 213, 220–29. But an injury is not "fairly traceable" to a defendant if it arises from the "independent action of some third party not before the court," *Lujan v. Defs. of Wildlife*, 504 U.S. 555,

560 (1992) (cleaned up), or a plaintiff's "purely voluntary decision" not attributable to a defendant, *Campeau v. Soc. Sec. Admin.*, 575 F. App'x 35, 38 (3d Cir. 2014). The fact that a third party apparently voluntarily reimbursed or chose to assume some portion of Ms. Lewandowski's copayment does not make her alleged injury fairly traceable to Defendants.

Second, Defendants' alleged failure to let Ms. Lewandowski use a copay assistance card to offset more of her out-of-pocket maximum is not a concrete, cognizable injury. This supposed injury does not "bear[] a close relationship to a harm traditionally recognized by American courts." *See Barclift v. Keystone Credit Servs., LLC*, 93 F.4th 136, 145–46 (3d Cir.), *cert. denied*, 145 S. Ct. 169 (2024). The Plan was not required to credit the copay assistance card payment toward Ms. Lewandowski's out-of-pocket maximum at all. Ex. D, Decl. ¶ 11. Ms. Lewandowski therefore cannot establish standing by claiming that she did not receive as much of a discretionary benefit—the counting of third-party copay assistance funds towards her out-of-pocket maximum—as she would have liked. Her argument reflects the Second Amended Complaint's attempt to manufacture financial harm while downplaying ways the Plan saved her and other participants money.

Third, Ms. Lewandowski argues she was injured despite exceeding the maximum out-of-pocket limit because she was "forced" to pay out-of-pocket costs

"sooner than she otherwise would have." SAC ¶ 231. But "accepting the lost time value of money as a cognizable constitutional injury is far from well established." *Taylor v. FAA*, 351 F. Supp. 3d 97, 102–03 (D.D.C. 2018). The Third Circuit has never found it sufficient, and other courts have confirmed that "conclusory proclamations" about "the lost time value of money" are not enough to show standing. *Id.*; *see also, e.g.*, *Tokyo Gwinnett, LLC v. Gwinnett County, Ga.*, 940 F.3d 1254, 1264 (11th Cir. 2019). It is likewise not enough here.

C. Plaintiffs do not allege they paid for any generic specialty drugs or were harmed by other challenged conduct.

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*" have standing. *TransUnion*, 594 U.S. at 427; *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.").

Under those principles, Plaintiffs lack standing to challenge the prices of generic specialty drugs, a category of drug on which the majority of their allegations rest but which they do not claim to have actually bought. The Second Amended Complaint claims that 42 generic specialty drugs were too expensive, *see* SAC ¶¶ 105–18, but it does not allege that either Plaintiff ever was prescribed or purchased any of those drugs. Plaintiffs therefore did not suffer an injury-in-fact

related to prices for those drugs. *Finkelman*, 810 F.3d at 195 (affirming dismissal for lack of Article III standing because plaintiff "never purchased" the allegedly overpriced tickets at issue).

Plaintiffs' other theories of imprudence fail for similar reasons. The Second Amended Complaint asserts that Defendants mismanaged the Plan by "agreeing to steer beneficiaries toward Express Scripts' mail-order pharmacy, Accredo," SAC ¶ 131, and "failing to disincentivize the use of high-priced branded drugs on the Plans' formulary in favor of lower-priced generics," *id.* ¶ 137. But Plaintiffs do not allege that they were ever "steered" toward Accredo, or that they ever used a branded drug when a lower-priced generic version was available. They lack standing to assert these theories. *TransUnion*, 594 U.S. at 427–28.

II. Counts One and Two fail to state a claim under Rule 12(b)(6) because Plaintiffs do not plausibly allege an imprudent process.

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). Plaintiffs' allegations must support the inference that Defendants used an imprudent process in choosing ESI as the Plan's pharmacy benefit manager and in negotiating drug prices with that entity. *See, e.g.*, *id.* At a minimum, Plaintiffs must allege facts indicating that the overall package of prescription drugs was unduly expensive compared to those in similarly situated healthcare plans—plans with coverage, access, and service needs similar to those of the J&J Plan. *See Mator v.*

Wesco Distrib., Inc., 102 F.4th 172, 188 (3d Cir. 2024); *Singh v. Deloitte LLP*, 123 F.4th 88, 95–96 (2d Cir. 2024) (holding in the retirement plan context that a plaintiff must establish that other plans are "apple-to-apple" comparators); *Matney v. Barrick Gold of N. Am.*, 80 F.4th 1136, 1148–49 (10th Cir. 2023) (same). Plaintiffs are not entitled to an inference of imprudence "simply from the allegation that a cost disparity exists." *Matney*, 80 F.4th at 1148–49; *see also, e.g.*, *McCaffree*, 2023 WL 2728787, at *14.

Plaintiffs come nowhere close to identifying "apples-to-apples" comparator plans whose plan sponsors made objectively superior decisions. *See Mator*, 102 F.4th at 187. The Second Amended Complaint's selective drug-by-drug comparison does not compare the Plan's overall package of health benefits (or even the narrower subset of prescription drug benefits) with any benchmark. Instead, Plaintiffs ask the Court to infer imprudence based on a cherry-picked subset of results: the prices of 42 generic specialty drugs and 15 generic non-specialty drugs, out of thousands of health services and drugs covered by the Plan. *See* SAC ¶¶ 105–18, 235–40. But the fiduciaries of the Plan negotiate *overall* Plan benefits—both medical and prescription drug benefits—with *all* participants in mind, not a subset who take the small number of drugs whose prices Plaintiffs are challenging. *See Mator*, 102 F.4th at 188; *McCaffree*, 2023 WL 2728787, at *14.

Allegations about the out-of-pocket costs for a select handful of drugs cannot support an inference of imprudence.

The differences between the retirement plans at issue in cases like *Mator* and healthcare plans like the J&J Plan only confirm Plaintiffs' failure to state a claim. Cases like *Mator* arise in the retirement plan context, where plaintiffs challenge the prudence of investment options on a retirement plan's menu. In those cases, however, the plan fiduciaries typically oversee perhaps a dozen or two dozen investment options—a small number of variables that comes nothing close to the thousands of drugs (and medical services) available through the Plan.

While the Second Amended Complaint includes allegations about the practices of a few other companies' health plans, SAC ¶¶ 177–91, none of these allegations suggest that any plan of comparable size, scope, and benefit levels pays less than the J&J Plan for the universe of health services and drugs covered by the Plan, or even for the narrower subset of prescription drugs Plaintiffs challenge. Most of these allegations simply describe measures that may have resulted in cost savings, without any suggestion that any other plan paid less in total, or even per person, than the J&J Plan. For example, Plaintiffs fail to allege that any of the so-called comparators provide equivalent coverage for lower premiums, copay amounts, and maximum out-of-pocket limitations.

Plaintiffs' most specific comparison is to PepsiCo's health plan, which allegedly had lower cost-sharing amounts than the Plan for a small subset of drugs identified in the Second Amended Complaint. SAC ¶ 179. Yet Plaintiffs allege nothing about total plan drug costs, premiums, out-of-pocket limitations, or whether the plan participants received similar access, service, or other benefits under PepsiCo's plan. *See Singh*, 123 F.4th at 97. These omissions prevent the Second Amended Complaint from plausibly supporting an inference of imprudence. *See id.*

Plaintiffs' allegations reflect a variety of alternative approaches taken by other companies' plans without demonstrating that any specific approach is imprudent. Again, there is no suggestion that the other companies' plans had the same level of benefits as the J&J Plan. *See Navarro*, 2025 WL 897717, at *8 n.9 ("Plaintiffs do not allege facts regarding the relative size and scope of those companies' plans."); *see, e.g.*, SAC ¶ 181 (discussing other plan with carve-out for specialty drugs); *id.* ¶ 183 (use of a pass-through PBM). Moreover, none of Plaintiffs' allegations suggest that the measures taken by other companies are consistently and commonly undertaken by prudent fiduciaries. As the *Navarro* court explained, "ESI is one of the 'Big 3' PBMs," so "[e]ven if [J&J] had conducted an 'open RFP process,' as Plaintiffs insist it should have, [SAC ¶ 95], it appears quite plausible that [J&J] still would have selected ESI—as many other

companies evidently have." 2025 WL 897717, at *8 n.9. In short, these allegations fail to provide a meaningful benchmark that would allow this Court to infer that J&J had a defective process.

That failure is especially telling because the Second Amended Complaint suggests that examples of comparable plans that paid less for comparable health benefits (or even for the narrower subset of prescription drug benefits) should be easy to find. In particular, the Second Amended Complaint points to alternative, pass-through PBMs that pass through their costs for prescription drugs and charge only administrative fees for running the whole program. *Id.* ¶ 57. It even points to a few plans that have switched to pass-through PBMs. *Id.* ¶¶ 179–82, 184–89. Yet Plaintiffs never demonstrate that these plans offer a package of benefits comparable to those offered under the J&J Plan at a lower cost.

Finally, Plaintiffs' suggestion of imprudence is implausible under the well-established standards of *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007). J&J's fiduciary and corporate interests are aligned to get the best overall deal at a reasonable cost, because J&J bears more than 80% of the cost of prescription drugs and services covered by the Plan. J&J has every incentive to negotiate the best overall deal for Plan services because J&J, not the participants, bears the vast majority of the Plan's expenditures. *Cf. Thole*, 590 U.S. at 545 (employers "are often on the hook for plan shortfalls," so "the last

thing a rational employer wants or needs is a mismanaged [benefits] plan"). Also relevant are the Supreme Court's recent reminders that *Iqbal* and *Twombly* apply with full force in ERISA class actions, that "[a]t times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs," and that, in assessing a motion to dismiss in the ERISA context, "courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes v. Northwestern Univ.*, 595 U.S. 170, 177 (2022).

Consistent with those incentives and principles, the obvious alternative explanation for the fact that some subset of drugs allegedly have high prices is that those prices were part of the best overall deal Defendants could negotiate for the thousands of drugs covered by the prescription drug program. *See Mator*, 102 F.4th at 184 & n.3 ("[T]he Rules require dismissal when fiduciary defendants offer an alternative explanation for their conduct that is obvious, natural, or simply more likely than the plaintiff's theory of misconduct." (quotation marks omitted)). The sheer number of covered drugs makes drug-by-drug negotiation impracticable. While Plaintiffs need not rule out every possible explanation for challenged prices, they must do more than point to a handful of drugs out of thousands with supposedly excessive costs.

CONCLUSION

The Court should dismiss the Second Amended Complaint, enter judgment against Plaintiffs and in favor of Defendants, and award Defendants any other appropriate relief.

Dated: April 22, 2025

Respectfully submitted,

/s/ David R. Kott

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI and ROBERT GREGORY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Johnson & Johnson Group Health Plan and its component plans, Plaintiffs, v. JOHNSON & JOHNSON and THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, Defendants.	Case No. 3:24-cv-00671-ZNQ-RLS

CERTIFICATION OF DAVID R. KOTT IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS COUNTS ONE AND TWO OF THE SECOND AMENDED COMPLAINT

David R. Kott, 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 McCarter & English, LLP, counsel for Johnson & Johnson and the Pension & Benefits Committee of Johnson & Johnson (together, "Defendants") in the above-captioned action. The information in this Certification is derived from my own personal knowledge as well as business records and documents that Johnson & Johnson considers reliable.

2. I make this Certification in support of Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint.

3. Attached hereto, and relied upon in the Brief in Support of Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint, are the following documents:

4. **Exhibit A** is a true and correct copy of the Johnson & Johnson Group Health Plan (as Amended and Restated Effective January 1, 2023).

5. **Exhibit B** is a true and correct copy of the 2022 Summary Annual Report for the Johnson & Johnson Group Health Plan.

6. **Exhibit C** is a true and correct copy of the Premier HSA Medical Plan Details Supplement for the Johnson & Johnson Group Health Plan (2023 Plan Year).

7. **Exhibit D** is a true and correct copy of the Declaration of Douglas Grant in Support of Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint.

8. **Exhibit E** is a true and correct copy of a Summary Plan Description entitled "Prescription Drug Coverage Details Supplement" for the Johnson & Johnson Group Health Plan (2023 Plan Year).

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

Dated: April 22, 2025
Newark, NJ

By: */s/ David R. Kott*
David R. Kott

Exhibit A

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)

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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

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.

Exhibit C

PREMIER HSA MEDICAL PLAN DETAILS SUPPLEMENT

2023 PLAN YEAR

TABLE OF CONTENTS

INTRODUCTION

If you are enrolled in the Premier HSA Medical Plan option available 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
- Prescription Drug Coverage Details Supplement

For the Salaried Retiree Medical Plan:

- Salaried Retiree Medical Plan for Post-4/1/85 Retirees/Dependents
- Prescription Drug Coverage Details Supplement

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) (see Note below). 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 Salaried Retiree Medical Plan.

Note: The Health Savings Account (HSA) component of the Premier HSA Medical Plan is not subject to ERISA; however, description and operation information about the Premier HSA Medical Plan is included in this document.

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 Plan Details/SPDs/Medicare Advantage EOC (Evidence of Coverage) for descriptions of particular benefit plans, or forms and certain other benefit materials, visit the *For Your Benefit (FYB) Website* at digital.alight.com/jnjbsc.

Alternatively, you can submit a request through the *FYB Website* to have copies of Plan Details/SPDs/Plan Descriptions 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 digital.alight.com/jnjbsc.

Calling The 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 below). The phone numbers that follow include voice prompts that will connect you directly to the Service Administrators for the Salaried Medical Plan.

To speak to 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 above 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 "Eligibility" 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*.

PREMIER HSA MEDICAL PLAN FEATURES

The Premier HSA Medical Plan has an Annual Deductible, In-Network and Out-of-Network Coinsurance and a Health Savings Account (HSA). In-Network and Out-of-Network Out-of-Pocket Maximums also apply.

The Service Administrator for the Premier HSA Medical Plan is Aetna. Bank of America is the custodian for the HSA. The Service Administrator for the prescription drug benefit is Express Scripts. See the Prescription Drug Coverage Details Supplement, available on the *FYB Website*, for information about prescription drug coverage.

Annual Deductible

The Annual Deductible is the amount of eligible medical expenses you are responsible to pay each Plan Year before the Premier HSA Medical Plan begins to pay a percentage of those expenses.

Annual Deductible amounts are combined for In-Network and Out-of-Network Services and are based on Coverage Category. The amounts are as follows:

ANNUAL DEDUCTIBLES	
COVERAGE CATEGORY	**ANNUAL DEDUCTIBLE**
You Only	$1,500
You + Spouse/Partner	$3,000
You + Child(ren)	$3,000
You + Family	$3,000
Spouse/Partner Only*	$1,500
Spouse/Partner + Child(ren)*	$3,000
Child Only*	$1,500
Children Only*	$3,000

* These Coverage Categories apply only to a spouse, partner or child(ren) of a retiree or Eligible Disabled Individual where covered family members (yourself and your Dependents) may be enrolled in different medical options.

Any combination of expenses from one or more family members can satisfy the Annual Deductible. With the exception of In-Network Preventive Care Services, approved over-the-counter and prescription tobacco cessation medications, generic female contraceptives, and other prescription drugs that are eligible to bypass the Annual Deductible as determined by Express Scripts; all eligible health care expenses, including prescription drug expenses, are subject to the Annual Deductible. (The “Prescription Drugs that do not require a Deductible under the Premier HSA Medical Plan” list is available on the *FYB Website* and on the Home Page of the Express Scripts website www.Express-Scripts.com/jnj.)

The Annual Deductible applies toward the Out-of-Pocket Maximums.

HSA

Provided you are enrolled in the Premier HSA Medical Plan and successfully pass the "customer identification process" described below, Bank of America will set up a Health Savings Account (HSA) for you.

Customer Identification Process: To process HSA enrollments, in accordance with Section 325 of the USA Patriot Act, Bank of America is required to obtain, verify and record information that identifies each person who opens an HSA. If this customer identification process fails or is incomplete, you must remain enrolled in the Premier HSA Medical Plan until the earlier of the next Annual Enrollment or a qualified status change, and you will not receive the Company contribution (if you are an employee) or be able to contribute to the HSA.

You can use your HSA to pay for qualified out-of-pocket medical expenses – such as your Annual Deductible and Coinsurance – now or in the future. Qualified medical expenses are defined by IRS Code 213(d) and include your Annual Deductible. For a complete list (IRS Publication 502), call the Internal Revenue Service (IRS) at 1-800-829-3676 or visit www.irs.gov and click on "Forms and Pubs." If you have enrolled in the Premier HSA Medical Plan, you may register at www.myhealth.bankofamerica.com to view a listing of qualified medical expenses.

Contributions

The IRS imposes a limit on how much can be contributed to your HSA each year from you and your employer combined. See the chart on the next page.

2023 Annual Contributions & Limits		
Family Status Category	**2023 Company Contribution (only applies to Active Employees)**	**2023 IRS Contribution Limits***
You Only	$500	$3,850
You + Spouse/Partner	$1,000	$7,750
You + Child(ren)	$1,000	$7,750
You + Family	$1,000	$7,750
Spouse/Partner Only**	$500	$3,850
Spouse/Partner + Child(ren)**	$1,000	$7,750
Child Only**	$500	$3,850
Children Only**	$1,000	$7,750

* Includes personal contributions, including voluntary catch-up contributions (see below); for active employees it also includes Company contributions.

** These Coverage Categories apply only to a spouse, partner or child(ren) of a retiree or Eligible Disabled Individual where covered family members (yourself and your Dependents) may be enrolled in different medical options.

Note: HSA contributions that are made by the Company are not guaranteed and may be amended or discontinued at any time at the sole discretion of the Company.

Important: Since you own the HSA, the responsibility for maintaining the annual HSA contribution limit resides with you, the account owner. Please note that any contributions in excess of the annual contribution maximum are included in gross income and are subject to an additional excise tax.

Catch-Up Contributions

If you are age 55 or older, you can make an additional catch-up contribution of up to $1,000 per year.

Making An Annual Contribution Election

If you are an employee, pretax payroll contributions to your HSA will not continue from one Plan Year to the next. If you are enrolled in the Premier HSA Medical Plan and do not make a new election during the Annual Enrollment Period for your contributions to your HSA, payroll contributions to your HSA for the following Plan Year will be zero. The Company contribution to your HSA will be made as long as you are considered an active employee, remain enrolled in the Premier HSA Medical Plan, and not enrolled in Medicare.

The Company makes an Employer Contribution to your Bank of America Health Savings Account at the beginning of the Plan Year. Your Employee Contributions will accrue with each payroll deduction throughout the Plan Year. Depending on the balance you have accrued, not all of your Employee Contribution funds will be immediately available for use at the beginning of the Plan Year.

If you have an expense that is greater than your current balance, you can choose to pay out of pocket and reimburse yourself from your account once your balance has grown. For more information, log on to www.myhealth.bankofamerica.com.

Tax Advantages

You don't pay Federal taxes (or state taxes, except in NJ and CA*****) on the funds deposited, the interest earned, or the funds you spend from the account on qualified health care expenses.

***** HSA contributions made by the Company or by the employee via pre-tax deductions are not eligible for tax-favored treatment for state tax purposes in NJ and CA.

Investment Opportunities

You can begin investing in an investment account once your HSA cash account balance reaches $1,000. You can invest any dollar amount in excess of the $1,000 minimum balance required to be held in the cash account of your HSA. If you have enrolled in investments and your cash account balance falls below $1,000, you will not be able to make any further investments until you replenish the cash account. Any deposits or pre-tax contributions will automatically be applied to your cash account until your balance is above $1,000; you may also liquidate some investments to replenish your cash account.

Bank of America offers a number of investment fund options. To get information about these options and/or to enroll in investments, log on to www.myhealth.bankofamerica.com.

Fees

There are fees associated with maintaining an HSA. As long as you are enrolled in the Premier HSA Medical Plan as an active participant, the Company will pay any applicable monthly or maintenance fees. When you are no longer enrolled in the Premier HSA Medical Plan for any reason (e.g., termination of employment or you enroll in another Company-sponsored Medical Plan option), you will become responsible for applicable fees.

Additionally, any fees other than the monthly or maintenance fees will always be your responsibility. For more information, check the fee schedule at www.myhealth.bankofamerica.com.

Using Your HSA

The cash account is the portion of your HSA that is used for your qualified medical expenses. When you choose to pay for qualified medical expenses from your HSA, you can do so using any of the following methods:

HSA Debit Card: Bank of America will send you a debit card which can be used by any Health Care Provider that accepts Visa®. The debit card draws money directly from your HSA.

HSA Online Bill Pay: Once enrolled, you can set up payees and make payments for qualified medical expenses from www.myhealth.bankofamerica.com.

Self-Reimbursement: Once your HSA is open, if you pay for a qualified medical expense out-of-pocket, you can reimburse yourself at any time using the functionality on www.myhealth.bankofamerica.com.

Taxes and Penalties

Taxes and penalties apply if HSA funds are used for non-qualified medical expenses or if you contribute more than the annual IRS maximum to your HSA, or are enrolled in Medicare Part A and/or Part B at the time a contribution is made to your HSA. It is your responsibility to manage your account and report HSA information (annual contributions, withdrawals, etc.) to the IRS on your annual Federal tax return. You are also responsible for completing any information relating to your HSA on your state income tax return.

NOTE TO ELIGIBLE DISABLED INDIVIDUALS AND RETIREES ABOUT AN HSA

If you had been enrolled in the Premier HSA Medical Plan with an HSA through Bank of America prior to becoming an Eligible Disabled Individual or retiring, your HSA will continue but there will no longer be any employer contributions. You may make contributions directly to Bank of America via checks or online transfers. (However, if you are receiving severance pay, you may continue to contribute to your HSA via payroll contributions. If your severance benefits continuation period extends into another Plan Year, your contributions to your HSA will be based on the annual election you make during Annual Enrollment.)

If you had not been enrolled in the Premier HSA Medical Plan with an HSA through Bank of America prior to becoming an Eligible Disabled Individual or retiring, but you enroll in the Premier HSA Medical Plan as an Eligible Disabled Individual or retiree, you may set up an HSA through Bank of America and make contributions directly to Bank of America via checks or online transfers. There will not be any employer contributions to your HSA. To process HSA enrollments, in accordance with Section 325 of the USA Patriot Act, Bank of America is required to obtain, verify and record information that identifies each person who opens an HSA (refer to the “customer identification process” described above). If this customer identification process fails or is incomplete, you must remain enrolled in the Premier HSA Medical Plan until the earlier of the next Annual Enrollment or a qualified status change, and you will not be able to contribute to the HSA.

See the “2023 IRS Contribution Limits” column in the chart on Page 6 as well as the ”Catch-up Contributions” section that follows.

Coinsurance For Eligible Services

After you meet the Annual Deductible, the Premier HSA Medical Plan and you share the cost of eligible health care expenses including eligible prescription drugs. This cost sharing is called Coinsurance. For eligible In-Network services, the Premier HSA Medical Plan pays 80% and you pay 20%. For eligible Out-of-Network services, the Premier HSA Medical Plan pays 60% and you pay 40%. Different Coinsurance levels apply for certain expenses. Refer to Page 24 for the Coinsurance levels that apply for Preventive Care Services. For the

Coinsurance percentages that apply for prescription drug expenses, refer to the Prescription Drug Coverage Details Supplement available on the *FYB Website*. Coinsurance percentages apply to the Pre-negotiated Fee for In-Network services or the applicable Recognized Charge for Out-of-Network services.

In-Network Services

Since In-Network care is charged at Pre-negotiated Fees that are usually lower than a Provider's normal charges and is covered at a higher Coinsurance level than Out-of-Network care, you will pay less in Coinsurance for In-Network services.

All Pre-negotiated Fees payable to a Participating Provider for medical services, including eligible prescription drug expenses (which include prescription drugs manufactured/marketed by the Johnson & Johnson Family of Companies) but excluding In-Network Preventive Care Services, are subject to the Annual Deductible, Coinsurance and the annual In-Network Out-of-Pocket Maximum.

Participating Providers submit claims directly to the Service Administrator. You do not have to file claims for services you receive from a Participating Provider. After a Participating Provider submits the claim on your behalf to the Service Administrator, you will be billed by the Participating Provider for your share of the covered expense (Annual Deductible or Coinsurance). You may be asked to pay your share of the covered expense(s) (Annual Deductible and/or Coinsurance) at the time of the visit. You may use your HSA to pay for your share of any covered expense.

To find a Participating Provider, call Member Services at the phone number on your ID card or log on to www.aetna.com.

Refer to the Summary Of The Premier HSA Medical Plan chart on Page 22 for more information on benefit levels.

Out-Of-Network Services

Recognized Charges for Non-Participating Provider medical services, including eligible prescription drug expenses, are subject to the Annual Deductible, Coinsurance and the annual Out-of-Network Out-of-Pocket Maximum.

If you use a Non-Participating Provider, you will usually pay more than you would have paid if you had received the services from a Participating Provider for the following reasons:

- For Non-Participating Providers, the Plan bases reimbursement on applicable Recognized Charges [for more information, see the "Recognized Charges" 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*)]. The Recognized Charge for a Non-Participating Provider will generally be higher than a Participating Provider's Pre-negotiated Fee for the same or similar service.
- The Plan generally pays a lower percentage of the Recognized Charge for Out-of-Network services than the percentage it pays of the Pre-negotiated Fee for In-Network services. As a result, your Coinsurance payments will typically be higher.

- Your Annual Deductible will apply to almost all services, including Out-of-Network Preventive Care Services.
- The Out-of-Pocket Maximum for Out-of-Network services is higher.
- Non-Participating Providers may charge you the full amount that they normally charge above the Recognized Charge. Your payments above the Recognized Charge will not apply to your Annual Deductible or Out-of-Pocket Maximum.

Collectively, these differences may require you to pay significantly more than you would have needed to pay had you instead received the services from a Participating Provider.

Important: You may need to pay your share of the covered expense (Annual Deductible or Coinsurance) at the time of your visit and file a claim form for services rendered by a Non-Participating Provider. Claim forms are available on the *FYB Website*.

You may use your HSA to pay for your share of the covered expense.

Out-Of-Pocket Maximum

Your Out-of-Pocket Maximum is the most you will pay for covered medical services and supplies in a Plan Year. The Out-of-Pocket Maximum consists of your Annual Deductible and your Coinsurance for all eligible medical expenses, including prescription drugs, you pay within a Plan Year. Any combination of covered medical expenses from one or more family members can satisfy the Out-of-Pocket Maximum.

There are separate In-Network and Out-of-Network Out-of-Pocket Maximums.

Your Out-of-Pocket Maximums are determined by whether your Regular Annual Salary is less than or equal to $85,000, or greater than $85,000- as well as your Coverage Category. Your Out-of-Pocket Maximums will not change during a Plan Year due to a salary change (unless there is a corresponding employment status change from part-time to full-time or full-time to part-time)

Once the Out-of-Pocket Maximums are met, eligible medical expenses, including prescription drugs, will be paid at 100% of Pre-negotiated Fees for In-Network services or 100% of applicable Recognized Charges for Out-of-Network services for the remainder of the Plan Year.

The Out-of-Pocket Maximums do not include ineligible expenses, amounts that exceed Recognized Charges, expenses that exceed Plan limits and penalties for non-compliance with Inpatient Precertification requirements.

OUT-OF-POCKET MAXIMUMS FOR PREMIER HSA MEDICAL PLAN				
COVERAGE CATEGORY	REGULAR ANNUAL SALARY* OF MORE THAN $85,000		REGULAR ANNUAL SALARY* OF $85,000 OR LESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
You Only	$3,500	$7,000	$2,500	$5,000
You + Spouse/ Partner	$5,250	$10,500	$3,750	$7,500
You + Child(ren)	$5,250	$10,500	$3,750	$7,500
You + Family	$7,000	$14,000	$5,000	$10,000
Spouse/Partner Only**	$3,500	$7,000	$2,500	$5,000
Spouse/Partner + Child(ren)**	$5,250	$10,500	$3,750	$7,500
Child Only**	$3,500	$7,000	$2,500	$5,000
Child(ren) Only**	$5,250	$10,500	$3,750	$7,500

Eligible expenses for both In-Network and Out-of-Network care apply to both the In-Network and Out-of-Network Out-of-Pocket Maximums. For eligible expenses received Out-of-Network that are above the In-Network Out-of-Pocket Maximum, you must pay the difference (between the two maximums) until your Out-of-Network Out-of-Pocket Maximum is met.

* See the definition 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*).

** These Coverage Categories apply only to a spouse, partner or child(ren) of a retiree or Eligible Disabled Individual where covered family members (yourself and your Dependents) may be enrolled in different medical options.

Retiree Reimbursement Arrangement (RRA)

If you are eligible for a Retiree Reimbursement Arrangement (RRA), it will be held in a dormant account until you retire, attain Medicare eligibility and enroll in one of certain retiree medical plan options. For more information, see the "Retiree Reimbursement Arrangement (RRA)" 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*.

Health Care Flexible Spending Account

If you are enrolled in the Premier HSA Medical Plan, you cannot enroll in Health Care Flexible Spending Account, or with certain limited exceptions, be covered under another health care Flexible Spending Account (e.g., through a spouse's Flexible Spending Account) within the same year. If you do so, there may be Federal tax implications.

Impact Of A Qualified Status Change On The Premier HSA Medical Plan

If you or a Dependent experiences certain qualified status changes during the year, you may be able to make a change to your medical coverage [refer to the "Changing Coverage"

section in the General/Administrative Information Plan Details (or for retirees, the Salaried Medical Plan SPD for Post-4/1/85 Retirees/ Dependents) available on the *FYB Website*]. Under the Premier HSA Medical Plan, making a change will have the following impact:

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN
You make a coverage change (such as adding or dropping a Dependent) and your Coverage Category remains the same	▪ If you are enrolled in the Premier HSA Medical Plan, there will be no change to your Deductible, RRA and Out-of-Pocket Maximums. Provided you are not enrolled in Medicare, you can participate in an HSA.
You make a coverage change (such as adding or dropping a Dependent) and there is a change to your Coverage Category	▪ If you are enrolled in the Premier HSA Medical Plan: – Your Deductible and Out-of-Pocket Maximums will change if your new Coverage Category changes from/to You Only to/from any other Coverage Category. Amounts previously met will be applied to your new family status category. – There will not be any impact to your RRA. – Provided you are not enrolled in Medicare, you can participate in an HSA.
You become ineligible for coverage	▪ Coverage for yourself and any covered Dependents stops. ▪ Your RRA is forfeited. It will not be reinstated if you again become eligible for coverage and re-enroll in the Premier HSA Medical Plan in a subsequent Plan Year. Your RRA will be reinstated if you become eligible for coverage in the same Plan Year. ▪ Any individual(s) losing coverage because of a qualifying event under COBRA will be offered the opportunity to continue in the Premier HSA Medical Plan. The Deductible and Out-of-Pocket Maximums will be based on the applicable elected Family Status Category; the Out-of-Pocket Maximums will also be based on your Regular Annual Salary prior to the event. ▪ If you enroll for COBRA coverage, any amounts applied toward your Deductible and Out-of-Pocket Maximums for eligible expenses incurred prior to your becoming ineligible for coverage will be transferred to your COBRA coverage. If one or all of your Dependents, but not you, elect COBRA coverage, this transfer will not occur. ▪ You can keep your HSA with Bank of America and make contributions directly to them or move it to another financial entity that offers Health Savings Accounts. There are no employer contributions to your HSA while on COBRA.
You are rehired in the same Plan Year	▪ You will be reinstated in the Premier HSA Medical Plan. Your Deductible and Out-of-Pocket Maximums will be reinstated. Claims for services incurred during your termination period are not covered (unless COBRA had been elected). Your RRA will be reinstated. ▪ If you had continued coverage under the Premier HSA Medical Plan during a severance benefits continuation period, or had elected COBRA during your

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN
	termination period, your coverage will be continuous and any amounts applied toward your Deductible and Out-of-Pocket Maximums for eligible expenses incurred during the termination period will be taken into account. ▪ No additional Company contribution will be made to your HSA during the year of rehire. Any prior employee payroll contributions to your HSA will be recalculated based on the remaining pay periods in the Plan Year, but you can enroll for, continue, change or suspend voluntary HSA payroll contributions. ▪ If you had maintained an HSA directly with Bank of America, upon rehire you may continue the direct HSA with Bank of America (in addition to continuing your HSA through the Premier HSA Medical Plan) or you can request Bank of America to combine your direct HSA under the HSA through the Premier HSA Medical Plan.
You are rehired in a different Plan Year	▪ If you elect the Premier HSA Medical Plan upon rehire, your Deductible, Out-of-Pocket Maximums and Company contribution to your HSA will be based on your elected Family Status Category and Regular Annual Salary. Regardless of when during the year you elect this coverage, these amounts are the full amounts – they are not pro-rated. Your RRA will not be reinstated. ▪ If you had continued coverage under the Premier HSA Medical Plan during a severance benefits continuation period and/or had elected COBRA during your termination period, your coverage under the Premier HSA Medical Plan will continue upon your re-employment. Any amounts applied toward your Deductible and Out-of-Pocket Maximums in the Plan Year you are rehired will be taken into account. Your RRA will continue. ▪ For payroll deduction purposes, if you choose to contribute to your HSA, the amount of the annual election to your HSA will be divided by the remaining number of pay periods within the same Plan Year from the date of your HSA election, through December 31 of that same Plan Year. ▪ If you had maintained an HSA directly with Bank of America, upon rehire you may continue the direct HSA with Bank of America (in addition to continuing your HSA through the Premier HSA Medical Plan) or you can request Bank of America to combine your direct HSA under the HSA through the Premier HSA Medical Plan.
You drop coverage voluntarily	▪ You can no longer make contributions to your HSA, but your prior HSA balance is available to you for qualified health care expenses. ▪ Your RRA is forfeited. ▪ COBRA will not be available.
You elect coverage under the Premier HSA Medical Plan for the first time	▪ Your Deductible, Out-of-Pocket Maximums and Contributions (if you are an employee) will be based on your elected Coverage Category; your Out-of-Pocket Maximums will also be based on your Regular Annual Salary. Regardless of when during the year you elect this coverage, these amounts are the full amounts – they are not pro-rated. ▪ You can choose to open an HSA and contribute directly to the financial entity

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN
	holding the HSA. For payroll deduction purposes for employees, if you choose to contribute to your HSA, the amount of the annual election to your HSA will be divided by the remaining number of pay periods within the same Plan Year from the date of your HSA election through December 31 of that same Plan Year. ▪ If applicable, your RRA will be transferred to UnitedHealthcare. ▪ If you enroll in the Premier HSA Medical Plan mid-year for the first time as the result of a change in place of residence or a special enrollment event, your coverage in the Premier HSA Medical Plan begins on the date of the event. However, unless the date of the event is the first of a month, the HSA component of the Premier HSA Medical Plan will not become effective until the first of the following month. For example, if you have a special enrollment event on March 15 and enroll in the Premier HSA Medical Plan within 60 days, your coverage in the Premier HSA Medical Plan will be effective March 15 and your HSA effective date will be April 1. If you have a special enrollment event on March 1 and enroll in the Premier HSA Medical Plan within 60 days, the effective date for both your coverage in the Premier HSA Medical Plan and your HSA will be March 1.
A Dependent loses eligibility for coverage (e.g., an ex-spouse due to a divorce, a child reaches the Plan's age limit, etc.)	▪ An employee can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to open or continue an HSA and contribute directly to the financial entity holding the HSA. ▪ When ineligibility results from a qualifying event under COBRA, the Dependent will be offered the opportunity to continue coverage in the Premier HSA Medical Plan through COBRA, provided timely notification of the event, when required, (e.g., in a divorce) has been given. ▪ The Dependent will not have access to the employee's/Eligible Disabled Individual's/retiree's RRA. ▪ Under the Premier HSA Medical Plan, the Deductible and Out-of-Pocket Maximums will be based on the Dependent's elected Coverage Category; the Out-of-Pocket Maximums will also be based on the employee's/Eligible Disabled Employee's/retiree's Regular Annual Salary. The Dependent will not have access to any amounts applied to the employees/Eligible Disabled Dependent's/retiree's Deductible or Out-of-Pocket Maximums from the period of coverage prior to their becoming ineligible, nor will they receive (or be able to make) any more HSA contributions. However, the Dependent can choose to open an HSA and contribute directly to the financial entity holding the HSA.
You are an Eligible Disabled Individual or a retiree and you and/or a covered Dependent become Medicare-eligible	If you and/or a Dependent had been enrolled in the Premier HSA Medical Plan at the time you and/or a covered Dependent become eligible for Medicare, the Medical Plan option that each individual (you as the Eligible Disabled Individual/retiree and each covered Dependent) will be eligible for will depend on your primary home ZIP code and each individual's Medicare status as described in the "Medical Options For Eligible Disabled Individuals" section in the Salaried Medical Plan Details (or for retirees, the "Eligible Medical Options"

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN
Important: When an individual becomes eligible for Medicare, it is very important to contact the Social Security Administration immediately to enroll for Medicare Parts A and B. **Note:** If you are age 65 or older at the time of retirement or, if you are in a deferred or suspended retiree medical status and are turning age 65, you must enroll for retiree medical coverage within 60 days of turning age 65 – otherwise, you will be considered to have permanently waived retiree medical coverage.	section in the Salaried Retiree Medical Plan SPD for Post-4/1/85 Retirees/Dependents) available on the *FYB Website*. ▪ If you and/or a covered Dependent(s) remain in the Premier HSA Medical Plan: – The Deductible and Out-of-Pocket Maximums will change if the new Coverage Category changes to "You Only," "Spouse/Partner Only," "Child Only," or "Children Only;" the Out-of-Pocket Maximums will also be based on your Regular Annual Salary. – Claims for any individual who is eligible for Medicare will be processed on a secondary basis to Medicare even though the individual is not enrolled in both Part A and Part B. – There will not be any impact to your RRA. – Provided you are not enrolled in Medicare, you can participate in an HSA. ▪ If you and/or a covered Dependent(s) are eligible for the Group Medicare Advantage PPO Plan, each eligible individual will be enrolled on an individual basis. Enrollment must be approved by the Centers for Medicare & Medicaid Services (CMS). (Until CMS approves enrollment, coverage will remain under the Premier HSA Medical Plan.) – UnitedHealthcare must give the individual a 21-day period to opt out of this coverage. – Therefore, the effective date will always be prospective and will generally be the first day of the second month after the individual has become eligible for Medicare. – Any claims for eligible services incurred prior to enrollment into the Group Medicare Advantage PPO Plan and received by the Premier HSA Medical Plan by the claim-filing deadline will be processed. ▪ After you have enrolled in the Group Medicare Advantage PPO Plan, your RRA will become available to you for qualified health care expenses. **Note:** For more information about the Group Medicare Advantage PPO Plan, see the Medicare Advantage EOC available on the *FYB Website*.

Family Members Employed By Or Retired From The Johnson & Johnson Family Of Companies

If your eligible spouse/partner is a retiree of the Johnson & Johnson Family of Companies (or you marry an employee/Eligible Disabled Individual/retiree of the Johnson & Johnson Family of Companies) or your eligible child is an employee/Eligible Disabled Individual of the Johnson & Johnson Family of Companies, under the Premier HSA Medical Plan, making a change to your medical coverage will have the following impact:

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN*
You make a coverage change (such as adding or	▪ There will be no change to your Deductible, Company contribution to your HSA (if you are an employee) and Out-of-Pocket Maximums. Amounts previously met will be applied to your new family status category.

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN*
dropping a Dependent) and your Family Status Category remains the same	▪ An employee can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to continue or open an HSA and contribute directly to the financial entity holding the HSA. ▪ If your spouse's/partner's Coverage Category does not change, your spouse's/partner's Deductible, Company contribution to their HSA (if they are an employee) and Out-of-Pocket Maximums will not change. ▪ There will not be any impact to your RRA.
You make a coverage change (such as adding or dropping a Dependent) and there is a change to your Family Status Category	▪ Your Deductible and Out-of-Pocket Maximums will change based on your new Coverage Category. – If your Coverage Category changes from You Only to any other Coverage Category, your Deductible will change to $3,000 and if you are an employee there will be an incremental Company contribution of $500 added to your HSA. – If your Coverage Category changes to You Only, your Deductible will change to $1,500 and if you are an employee the Company contribution to your HSA already made for the current Plan Year will not be recouped. ▪ An employee can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to open an HSA and contribute directly to the financial entity holding the HSA. ▪ Similar rules would apply if there are changes to your spouse's/partner's Coverage Category. ▪ There will not be any impact to your RRA.
One of you adds the other spouse/partner who had their own coverage under the Premier HSA Medical Plan; accordingly, the other spouse/partner drops coverage	▪ If your or your spouse's/partner's Coverage Category changes from You Only to any other Coverage Category, the Deductible and Out-of-Pocket Maximums of the employee/Eligible Disabled Individual/retiree who adds the other spouse/partner will change based on their new Coverage Category and for an employee there will be an incremental Company contribution of $500 added to their HSA. ▪ An employee who is adding their spouse/partner can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual/retiree who is adding their spouse/partner can open or continue an HSA and contribute directly to the financial entity holding the HSA. ▪ Voluntary HSA payroll contributions will cease for the employee who drops coverage to become covered as a Dependent, but employee who drops coverage can keep their HSA with Bank of America and make contributions directly to Bank of America. ▪ The RRA will be forfeited for the employee/Eligible Disabled Individual/retiree who drops coverage to become covered as a Dependent.
You add your child who had their own coverage under the	▪ If your Coverage Category does not change due to adding your child, there will be no change to your Deductible, Company contribution to your HSA (if you are an employee) and Out-of-Pocket Maximums.

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN*
Premier HSA Medical Plan, and your child drops coverage as an employee	▪ If your Coverage Category changes, your Out-of-Pocket Maximums will change based on your new Coverage Category; they will also be based on your Regular Annual Salary. ▪ If your Coverage Category changes from You Only to any other Coverage Category, your Deductible will change to $3,000 and if you are an employee there will be an incremental Company contribution of $500 added to your HSA. ▪ When your child drops coverage to become covered as your Dependent, they will forfeit their RRA. ▪ An employee can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to continue or open an HSA and contribute directly to the financial entity holding the HSA. ▪ Your child's voluntary HSA payroll contributions will cease when your child drops coverage to become covered as your Dependent, but your child can keep their HSA with Bank of America and make contributions directly to Bank of America.
You drop your child from your coverage, and your child enrolls under the Premier HSA Medical Plan as an employee	▪ If your Coverage Category does not change due to dropping your child, there will be no change to your Deductible, Company contribution to your HSA (if you are an active employee) and Out-of-Pocket Maximums. ▪ If your Coverage Category changes, your Out-of-Pocket Maximums will change based on your new Coverage Category. ▪ If your Coverage Category changes to You Only, your Deductible will change to $1,500 and if you are an employee the Company contribution to your HSA already made for the current Plan Year will not be recouped. ▪ An employee can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to continue or open an HSA and contribute directly to the financial entity holding the HSA. ▪ There will not be any impact to your RRA. ▪ If your child elects coverage under the Premier HSA Medical Plan, their Deductible, Out-of-Pocket Maximums and Company contribution to their HSA will be based on their elected Coverage Category; the Out-of-Pocket Maximums will also be based on their Regular Annual Salary. Regardless of when during the year they elect this coverage, these amounts are the full amounts – they are not pro-rated (unless your child had their own coverage under the Premier HSA Medical Plan earlier in the same Plan Year, in which case, any amounts applied toward their Deductible and Out-of-Pocket Maximums will be reinstated). ▪ For payroll deduction purposes, if your child chooses to contribute to their HSA, the amount of the annual election to their HSA will be divided by the remaining number of pay periods within the same Plan Year from the date of their HSA election, through December 31 of that same Plan Year.
One of you drops the other	▪ For the employee/Eligible Disabled Individual/retiree who drops the other spouse/partner, their Out-of-Pocket Maximums will change based on the new

EVENT	IMPACT ON PREMIER HSA MEDICAL PLAN*
spouse/partner as a result of a divorce or dissolution of a partnership	Coverage Category. For an employee, the Company contribution already made to their HSA for the current Plan Year will not be recouped. ▪ If the employee's/Eligible Disabled Individual's/retiree's Coverage Category changes to You Only, their Deductible will change to $1,500. ▪ The employee who drops the other spouse/partner can enroll for, continue, change or suspend voluntary HSA payroll contributions. An Eligible Disabled Individual or retiree can choose to continue or open an HSA and contribute directly to the financial entity holding the HSA. ▪ There will not be any impact the RRA of the employee/Eligible Disabled Individual/retiree who drops the other spouse/partner. ▪ The spouse/partner whose coverage has been dropped can elect coverage under the Premier HSA Medical Plan and their Deductible, Out-of-Pocket Maximums and Company Contribution to their HSA (if an employee) will be based on their elected Coverage Category; the Out-of-Pocket Maximums will also be based on their Regular Annual Salary. Regardless of when during the year they elect this coverage, these amounts are the full amounts – they are not pro-rated (unless the spouse/partner whose coverage has been dropped had their own coverage under the Premier HSA Medical Plan earlier in the same Plan Year, in which case, any amounts applied toward their Deductible and Out-of-Pocket Maximums will be reinstated). If an employee, they can enroll for voluntary HSA payroll contributions; if an Eligible Disabled Individual/retiree, they can open an HSA and contribute directly to the financial entity holding the HSA.

***** If you are enrolled in the Premier HSA Medical Plan, you may make a change to your annual HSA election at any time. All changes are prospective and the payroll deduction will be adjusted with the next practical payroll cycle.

Any individual(s) losing coverage as a result of a COBRA qualifying event may be offered an opportunity to continue their group medical coverage through COBRA. For more information, see the "COBRA Coverage" 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*.

SUMMARY OF THE PREMIER HSA MEDICAL PLAN

The following chart provides an overview of some of the different types of medical expenses and how they are paid under the Premier HSA Medical Plan when you receive Medically Necessary In-Network or Out-of-Network care. All reimbursements are based on Prenegotiated Fees (for Participating Providers) or applicable Recognized Charges (for Non-Participating Providers) as determined by the Service Administrator. For Medicare-eligible individuals (Eligible Disabled Individuals or retirees and their covered Dependents), reimbursements are based on the Medicare allowable charge or limiting charge. For more information on eligible services and supplies covered under the Premier HSA Medical Plan, refer to the "Eligible Expenses" section in the Salaried Medical Plan Details (or for retirees, the Retiree Medical Plan SPD for Post-4/1/85 Retirees/Dependents) available on the *FYB Website*.

PREMIER HSA MEDICAL PLAN		
COVERED SERVICE	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS**
Acupuncture	80% after Deductible	60% after Deductible
Allergy Injections	80% after Deductible	60% after Deductible
Ambulance	80% after Deductible if Service Administrator determines a medical emergency exists Non-emergency, Medically Necessary services may be covered in accordance with the Service Administrator's guidelines, generally at 80% after Deductible for In-Network Providers and 60% after Deductible for Out-of-Network Providers. In general, other than Medically Necessary ambulance expenses, transportation services are not covered. This exclusion does not apply to expenses for qualified cancer clinical trials (see page 19) and eligible transplants when using a facility more than 100 miles away from your home, as well as medically non-necessary transport. • Available when member is confined 100 miles or more from their principal residence and below administrative criteria are met: ○ Transport back to the area of the member's principal residence only ○ Coverage limited to the patient only, companion services not included ○ Anticipated length of stay should be greater than 30 days ○ Transport within the United States only, no international coverage ○ Participating providers must be used if available	

	○ There must be agreement between the sending and receiving facilities, as well as the transport provider, that the member is stable enough to travel ○ Lowest level of clinically appropriate transport should be utilized, whether it be ground or air ○ Transport of mortal remains not covered	
Ambulatory Surgical Care Facility	80% after Deductible	60% after Deductible
Anesthesia	80% after Deductible	60% after Deductible
Applied Behavior Analysis Therapy	80% after Deductible	60% after Deductible
Artificial Insemination	80% after Deductible	60% after Deductible

PREMIER HSA MEDICAL PLAN		
COVERED SERVICE	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS**
Behavioral Health/Substance Abuse Inpatient Care and Behavioral Health/ Substance Abuse Structured Outpatient Treatment Programs (in lieu of Inpatient Care). Inpatient Care must be pre-certified. Failure to pre-certify results in a $300 penalty. See also the "General Exclusions And Limitations" 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*.	80% after Deductible	60% after Deductible
Behavioral Health/Substance Abuse Individual Outpatient Care	80% after Deductible	60% after Deductible
Blood and Blood Plasma/Autologous (self-donated) Blood	80% after Deductible	60% after Deductible
Cancer Clinical Trials	100% after Deductible, for routine patient services not covered by the Cancer Clinical Trial (regardless of whether a Participating or Non-Participating Provider) **Note:** Patient costs associated with other approved (as determined by the Service Administrator) non-cancer clinical trials are covered as follows: In-Network – 80% after Deductible; Out-of-Network – 60% after Deductible	
Chemotherapy/Radiation	80% after Deductible	60% after Deductible
Chiropractic Care (limit of up to 30 non-maintenance visits combined In-Network and Out-of-Network)	80% after Deductible	60% after Deductible
Contraceptive Devices and Injectables administered in a Doctor's office	100%, no Deductible	60% after Deductible
Dental Services – Accidental Injury Only	80% after Deductible	60% after Deductible
Diabetes Education	80% after Deductible	60% after Deductible
Drugs and Medication	See the Prescription Drug Coverage Details Supplement available on the *FYB Website*	

PREMIER HSA MEDICAL PLAN		
COVERED SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Durable Medical Equipment (DME) (except certain products manufactured/marketed by the Johnson & Johnson Family of Companies, which are paid at 100% after Deductible)	80% after Deductible	60% after Deductible
Emergency Room Care*	80% after Deductible if Service Administrator determines a medical emergency exists 60% after Deductible if Service Administrator determines a medical emergency does not exist	
Fertility Assistance for Participants, excluding children [In-Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT), Intracytoplasmic Sperm Injection (ICSI) and Zygote Intra Fallopian Transfer (ZIFT)] $35,000 lifetime maximum (includes prescription drugs related to Fertility Assistance) For more information, see the Salaried Medical Plan Details (or for retirees, the Salaried Retiree Medical Plan SPD for Post-4/1/85 Retirees/ Dependents) and the Prescription Drug Coverage Details Supplement available on the *FYB Website*	80% after Deductible	60% after Deductible
Genetic Counseling	80% after Deductible	60% after Deductible
Genetic Testing	80% after Deductible	60% after Deductible
Hearing Aids $3000 maximum per ear, per hearing aid, every three years	80% after Deductible	60% after Deductible
Hemodialysis	80% after Deductible	60% after Deductible
Home Health Care Visits (part-time or intermittent)	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Hospital Ancillary Services (inpatient)	80% after Deductible	60% after Deductible
Hospital Room and Board (semi-private) and Skilled Nursing Facility. Inpatient Care must be pre-certified. Failure to pre-certify results in a $300 penalty. See also the "General Exclusions And Limitations"	80% after Deductible	60% after Deductible

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*.		
Hospital Services—Outpatient	80% after Deductible	60% after Deductible
Laboratory, X-ray and Imaging—Outpatient	80% after Deductible	60% after Deductible
Maternity Care (non-preventive)	80% after Deductible **Note:** In-Network preventive prenatal care is covered at 100%, no Deductible	60% after Deductible
Nutritional Counseling	80% after Deductible	60% after Deductible
Occupational Therapy	80% after Deductible	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible
Oxygen	80% after Deductible	60% after Deductible
Physical Therapy	80% after Deductible	60% after Deductible
Physician Services—Inpatient (consultations and surgery)	80% after Deductible	60% after Deductible
Physician Services—Outpatient (visits and surgery)	80% after Deductible	60% after Deductible
Podiatric Services	80% after Deductible	60% after Deductible
Pre-Admission Testing	80% after Deductible	60% after Deductible

PREMIER HSA MEDICAL PLAN		
COVERED SERVICE	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS**
Prescription Drug Benefits	See the Prescription Drug Coverage Details Supplement available on *the FYB Website*	
Preventive Care Service [see the Preventive Care Services charts 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*]	100%, no Deductible	60% after Deductible
Note that if it is an eligible Plan expense, a test performed due to a specific diagnosis is covered at any time under the Plan, subject to the Deductible at 80% if In-Network or 60% if Out-of-Network.		
Private Duty Nursing	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Second and Third Physician Opinions	80% after Deductible	60% after Deductible
Speech Therapy	80% after Deductible	60% after Deductible
Surgery	80% after Deductible	60% after Deductible
Travel and Lodging	Travel and lodging for complex and rare complicated conditions per service administrator guidelines	
Urgent Care Facility	80% after Deductible	60% after Deductible

***** *For Emergency Care, the benefit determination is based on the following: the Prenegotiated Fee when care is provided by a Participating Provider; the amount billed when the Service Administrator determines a medical emergency exists and care is provided by a Non-Participating Provider; and the applicable Recognized Charge when the Service Administrator determines a medical emergency does not exist and care is provided by a Non-Participating Provider. For more information, see the "Emergency Care" 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.*

Exhibit D

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI and ROBERT GREGORY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Johnson & Johnson Group Health Plan and its component plans, Plaintiffs, v. JOHNSON & JOHNSON and THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, Defendants.	Case No. 3:24-cv-00671-ZNQ-RLS

DECLARATION OF DOUGLAS GRANT IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS COUNTS ONE AND TWO OF THE SECOND AMENDED COMPLAINT

Douglas Grant hereby states as follows:

1. I have been employed at Johnson & Johnson for approximately 20 years. I am currently the Head of Global Compensation and Benefits. The information outlined in this declaration is derived from my own personal knowledge as well as business records, documents, and data that Johnson & Johnson considers reliable.

2. The Johnson & Johnson Group Health Plan (the "Plan") offers participants multiple healthcare plan options, and each of those options has different cost-sharing provisions and amounts, such as premiums. Premium amounts are established before each Plan year and do not change during the course of the year. Under Section 4.01 of the Group Plan Document (Ex. A), which governs all available plan options, J&J, as the Plan Sponsor, has complete discretion to set premiums and other participant cost-sharing obligations, "including, but not limited to, deductibles, copayments, coinsurance percentages, out-of-pocket maximums, and lifetime maximums." The Pension & Benefits Committee (the "Committee"), in its settlor (non-fiduciary) capacity on behalf of the Sponsor, establishes premiums and other participant cost-sharing obligations. Generally, when establishing contribution levels, the Committee considers factors such as (but not limited to) group health plan market trends, administrative expenses, non-drug medical costs, the costs of other prescription drugs and

categories of drugs, historical cost-sharing levels under the Plan, and other internal or external factors impacting employees. For example, in light of the COVID-19 pandemic, the Committee elected not to increase participants' premiums (in dollar terms) for the 2022 Plan year relative to the 2021 Plan year.

3. No formula or agreement governs the setting of premiums.

4. Ann Lewandowski was a participant in the Plan from 2022 until October 2024.

5. In each year, Ms. Lewandowski chose the Premier HSA Medical Plan ("Premier HSA"). She elected individual coverage (coverage only of herself, not a spouse or any children). Under this plan, Ms. Lewandowski paid monthly premiums.

6. Under the Premier HSA option in each year Ms. Lewandowski was a participant, the Plan and participants shared healthcare costs (other than premiums) as follows:

a. Before the Plan started to pay benefits, a participant had to pay an initial amount (a "deductible") for covered services, including medical services and prescription drugs. There were limited exceptions to this requirement. For example, participants did not have to pay anything, even a deductible, for certain in-network preventive care services and prescription drugs. Under the Premier

HSA option, Ms. Lewandowski's deductible was $1,400 in 2022, $1,500 in 2023, and $1,600 in 2024, which in each year was the lowest IRS-permitted deductible for individual coverage under an HSA-eligible health plan. In each year, Johnson & Johnson also gave Premier HSA participants with individual coverage, including Ms. Lewandowski, a $500 contribution to their HSA accounts that could be used to offset the deductible.

b. After the participant paid the annual deductible, the Plan generally paid 80% of the allowed amount (negotiated rate) under the Plan for covered in-network health services. In other words, the Plan paid 80% of this cost while the participant paid the remaining 20%. That 20% is referred to as "coinsurance."

c. For prescription drugs, there were additional limitations on cost-sharing. If a participant met her annual deductible and obtained a drug at an in-network pharmacy, the participant generally paid 20% of the cost of the drug (15% for drugs ordered through the mail order pharmacy available under the Plan), up to a maximum of $125 ($150 starting with the 2025 Plan year) per prescription for up to a 30-day retail supply (or up to a 90-day supply for mail ordered drugs). The Plan paid the remaining amount.

d. The Plan also limited participants' annual total cost-sharing obligations through a total out-of-pocket maximum. After a participant met the annual deductible and paid a certain additional amount for coinsurance, the participant had no further cost-sharing obligations for covered in-network healthcare expenses that year. Under the Premier HSA option, Ms. Lewandowski's out-of-pocket maximums in each of 2022, 2023, and 2024 were $3,500 for in-network services. This $3,500 out-of-pocket maximum was considerably lower than the cap on annual out-of-pocket maximums that HSA-eligible plans like the Premier HSA could have established under applicable law and IRS guidance ($7,050 in 2022, $7,500 in 2023, and $8,050 in 2024).

7. Ms. Lewandowski incurred significant medical expenses in each of 2022, 2023, and 2024. As a result, she reached her maximum out-of-pocket cost in each year, such that, for the vast majority of the healthcare expenditures made on her behalf under the Plan, she had no cost-sharing obligations. Ms. Lewandowski met her annual in-network limit on cost-sharing in August 2022, May 2023, and April 2024.

8. The chart below shows the healthcare spending totals for Ms. Lewandowski for each year she participated in the Plan, based on the date the

services or drugs were provided: (a) allowed amount, (b) deductible, (c) coinsurance, (d) patient responsibility, and (e) Plan responsibility, *i.e.*, the amount the Plan was responsible for paying.[1]

Year	Allowed Amount	Deductible	Coinsurance	Total Patient Responsibility	Total Plan Responsibility
2022	$171,535	$1,400	$2,100	$3,500	$168,035
2023	$201,382	$1,500	$2,000	$3,500	$197,882
2024	$92,289	$1,600	$1,900	$3,500	$88,789

9. The allowed amount is the amount paid to providers for medical services and prescription drugs. It includes amounts the Plan was responsible for paying and, if applicable, the amounts payable by Ms. Lewandowski in deductibles and coinsurance. The deductible is the amount Ms. Lewandowski was required to pay for covered services each year before the Plan started to pay. The coinsurance is the amount Ms. Lewandowski paid for services after meeting her deductible but before she met her out-of-pocket maximum. And the last two columns show the portion of the approved amounts that Ms. Lewandowski and the Plan, respectively, were expected to pay. For example, for services provided in 2023, the Plan paid $197,882 for healthcare services and products (including prescription drugs) provided to Ms. Lewandowski. Ms. Lewandowski was credited for paying $3,500,

[1] These figures are based on the data available to Johnson & Johnson as of the date of this declaration.

reflecting her deductible and coinsurance amounts, up to her maximum out-of-pocket limit. By May 2024, Ms. Lewandowski had met her out-of-pocket limit, meaning she had no further cost-sharing obligations for in-network services for the remainder of 2024.

10. Virtually all of Ms. Lewandowski's healthcare expenditures were for medical services, not prescription drugs payable under the prescription drug benefit administered by Express Scripts (ESI). In each of 2022, 2023, and 2024, Ms. Lewandowski would have reached her maximum out-of-pocket limit based solely on benefits provided under her health plan, without regard to the cost of prescription drugs obtained under the prescription drug benefit. For example, prescription drug costs obtained under the prescription drug benefit were just $445.13 (0.26%) of the allowed amounts for Ms. Lewandowski's covered healthcare expenses for 2022, $339.77 (0.17%) for 2023, and $246.12 (0.26%) for 2024. These data show that regardless of how much Ms. Lewandowski's prescription drugs cost (and regardless of how much she contends in this lawsuit they should have cost), the cost of prescription drugs obtained under the prescription drug benefit administered by ESI had no impact on her total out-of-pocket expenses under the Plan.

11. For example, for services provided in 2023, Ms. Lewandowski incurred approximately $201,042 (based on allowed amounts) for medical benefits

alone, compared to approximately $340 for prescription drugs obtained under the prescription drug benefit administered by ESI. All of these were in-network expenses. As noted above, the Plan generally paid 80% of allowed amounts, and the patient was responsible for the remaining 20%. Twenty percent of the $201,042 for non-drug medical expenses is approximately $40,208. Of that amount, Ms. Lewandowski was credited for paying her $1,500 deductible and another $2,000 in coinsurance until she reached the maximum in-network out-of-pocket limit of $3,500. The Plan paid the remaining balance.[2] The same analysis applies to 2022 and 2024. Thus, the cost of Ms. Lewandowski's prescription drugs had no impact on her out-of-pocket Plan expenditures. Ms. Lewandowski also acknowledges that the discount she received under a copay assistance program was credited toward her annual deductible and out-of-pocket maximum amounts for the 2023 Plan year. However, the Plan was not required to credit the copay assistance amount.

12. J&J employees who meet relevant requirements have access to medical options under the Plan upon retirement from the Company. Plaintiff Robert Gregory has been a participant in the Plan as a retiree since October 2020.

13. From October 2020 through December 2024, when the option was discontinued, Mr. Gregory had the Aetna HRA Plan ("HRA"). He switched to the

[2] Ms. Lewandowski's 2023 infusion at a medical facility was a medical benefit under the Plan, not part of the prescription drug benefit.

Aetna PPO Plan ("PPO") effective January 1, 2025. Mr. Gregory elected family coverage. Under both the HRA plan and the PPO plan, Mr. Gregory has paid monthly premiums. As described above, the premium amounts are established before each Plan year and do not change during the course of the year.

14. In each year in which Mr. Gregory had the HRA option as a retiree, the Plan and HRA participants shared healthcare costs (other than premiums) as follows:

a. Mr. Gregory's family deductible was $2,000 in each year. In each year, Johnson & Johnson also gave HRA participants with family coverage, including Mr. Gregory, a $1,000 company contribution that could be used to offset the deductible.

b. After the participant paid the annual deductible, the Plan generally paid 80% of the allowed amount (negotiated rate) under the Plan for covered in-network health services – *i.e.*, the Plan paid 80% of this cost while the participant paid the remaining 20% as coinsurance.

c. If a participant obtained a drug at an in-network pharmacy, the participant generally paid 20% of the cost of the drug (15% for drugs ordered through the mail order pharmacy available under the Plan), up to a maximum of $125 per prescription for up to a 30-day

retail supply (or a 90-day supply for mail ordered drugs). The Plan paid the remaining amount.

d. The HRA plan had "first dollar" coverage for prescription drugs, meaning participants did not have to meet their deductible first for prescription claims. In other words, for prescription drugs, participants such as Mr. Gregory owed only coinsurance up to the out-of-pocket maximum. His family out-of-pocket maximums in each of 2020, 2021, 2022, 2023, and 2024 were $12,000 for in-network services.

15. As of 2025, under the PPO option, the Plan and participants such as Mr. Gregory share healthcare costs (other than premiums) as follows:

a. Mr. Gregory's family deductible is $1,000.

b. After the participant pays the annual deductible, the Plan generally pays 80% of the allowed amount (negotiated rate) under the Plan for covered in-network health services – *i.e.*, the Plan pays 80% of this cost while the participant pays the remaining 20% as "coinsurance."

c. If a participant has met his annual deductible and obtains a drug at an in-network pharmacy, the participant generally pays 20% of the cost of the drug (15% for drugs ordered through the mail order

pharmacy available under the Plan), up to a maximum of $150 per prescription for up to a 30-day retail supply (or a 90-day supply for mail ordered drugs). The Plan pays the remaining amount.

d. Mr. Gregory's family out-of-pocket maximum is $12,000 for in-network services.

16. The chart below shows the prescription drug spending totals for Mr. Gregory and his family for each year Mr. Gregory participated in the Plan as a retiree, based on the date the prescription drugs were provided: (a) allowed amount; (b) patient responsibility; and (c) Plan responsibility.[3]

Year	**Allowed Amount**	**Total Patient Responsibility**	**Total Plan Responsibility**
2020 (October through December)	$3,040.62	$708.18	$2,332.44
2021	$10,675.03	$2,355.14	$8,319.89
2022	$7,847.62	$1,740.92	$6,106.70
2023	$47,205.04	$1,160.98	$46,044.06
2024	$57,649.74	$1,510.90	$56,138.84
2025 (through March)	$922.25	$170.34	$751.91

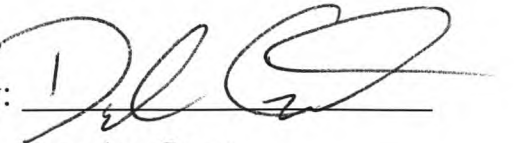
[3] These figures are based on the data available to Johnson & Johnson as of the date of this declaration.

17. The chart below shows the following overall healthcare spending totals for Mr. Gregory and his family for each year Mr. Gregory participated in the Plan as a retiree, based on the date the services or drugs were provided: (a) allowed amount; (b) patient responsibility; and (c) Plan responsibility.[4]

Year	Allowed Amount	Total Patient Responsibility	Total Plan Responsibility
2020 (October through December)	$10,692.70	$1,169.50	$9,523.20
2021	$65,082.63	$8,920.93	$56,161.70
2022	$31,858.03	$4,296.44	$27,561.59
2023	$112,876.88	$6,285.50	$106,591.38
2024	$121,799.78	$5,257.37	$116,542.41
2025 (through March)	$15,287.90	$1,117.69	$14,170.21

18. Based on my current knowledge and the documents, data, and information provided to me, I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 22, 2025
New Brunswick, NJ

By: 
Douglas Grant

[4] These figures are based on the data available to Johnson & Johnson as of the date of this declaration.

Exhibit E

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.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI and ROBERT GREGORY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Johnson & Johnson Group Health Plan and its component plans, Plaintiffs, v. JOHNSON & JOHNSON and THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, Defendants.	Case No. 3:24-cv-00671-ZNQ-RLS

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS AND DISMISSING COUNTS ONE AND TWO OF THE SECOND AMENDED COMPLAINT

THIS MATTER having come before the Court upon the motion of McCarter & English, LLP, counsel for Johnson & Johnson and the Pension &

Benefits Committee of Johnson & Johnson (together, "Defendants") for an Order granting Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint filed by Plaintiffs Ann Lewandowski and Robert Gregory ("Plaintiffs"), and on notice to Cohen Milstein Sellers & Toll PLLC, Fairmark Partners, LLP, and Wheeler, Diulio & Barnabei, P.C., counsel for Plaintiffs, 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 _____ 2025,

ORDERED that Defendants' Motion to Dismiss Counts One and Two of the Second Amended Complaint is hereby **GRANTED**; and

ORDERED that Counts One and Two against Defendants in Plaintiffs' Second Amended Complaint are hereby dismissed [with prejudice (if based on motion under Rule 12(b)(6))] or [without prejudice (if based on motion under Rule 12(b)(1))].

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

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ANN LEWANDOWSKI and ROBERT GREGORY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Johnson & Johnson Group Health Plan and its component plans, Plaintiffs, v. JOHNSON & JOHNSON and THE PENSION & BENEFITS COMMITTEE OF JOHNSON & JOHNSON, Defendants.	Civil Action No. 3:24-cv-00671-ZNQ-RLS Honorable Zahid N. Quraishi Honorable Rukhsanah L. Singh **CERTIFICATION OF SERVICE**

DAVID R. KOTT, 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 McCarter & English, LLP, attorneys for Defendants.

2. On April 22, 2025, I caused the following documents to be filed via ECF with the Clerk of the United States District Court for the District of New Jersey and served upon all parties of record via ECF:

a. Defendants' Notice of Motion to Dismiss Counts One and Two of the Second Amended Complaint;

b. Brief and Certification of David R. Kott, Esq. in Support of Defendants' Notice of Motion to Dismiss Counts One and Two of the Second Amended Complaint;

c. Proposed Form of Order, and;

d. This Certification of Service.

3. On April 22, 2025, courtesy copies of the aforementioned documents were served via First Class mail to:

Honorable Rukhsanah L. Singh, U.S.M.J.
United States District Court for the District of New Jersey
Clarkson S. Fisher Federal Building and
United States Courthouse
402 East State Street, Room 7 W
Trenton, NJ 08608

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

s/David R. Kott
DAVID R. KOTT

Dated: April 22, 2025