Claim, Appeal and Legal Information

Contents:

This section of the Summary Plan Description (or “SPD”) summarizes important legal information about the Edward D. Jones & Co. Employee Health & Welfare Program (the “Plan”). This section of the SPD describes the processes and procedures for filing a claim for benefits under the Plan.

This SPD is effective January 1, 2023. This SPD, and other various other documents (such as relevant Plan documents, insurance policies, certificates of coverage, and other benefit summaries) currently in effect taken together are the "Plan documents". Your rights are governed by the terms of the Plan documents. Any questions concerning the Plan shall be determined in accordance with the terms of the relevant Plan documents.

The Plan Administrator retains the authority to resolve any conflict or inconsistency between the SPD and any other Plan document. No person, other than the Plan Administrator or their authorized delegate, has the authority to make any representation which contradicts the Plan documents.

Terms to Know

Business Associate. A third party that provides services to the group health plans offered through the “Plan” by providing management services such as claims processing and administration, data analysis, health management, quality assurance, and billing, actuarial, accounting, consulting, or other services. A Business Associate may come into contact

with “protected health information” created and maintained by the Plan. To protect this information, all Business Associates must sign a written agreement that requires the Business Associate to abide by the federal privacy and security rules imposed under HIPAA.

Claim Administrator. Insurers and/or other third-party administrators who have been delegated certain claims administration functions for the various benefit programs offered through the Plan.

Plan. Edward D. Jones & Co. Employee Health & Welfare Program.

Plan Sponsor. The Plan Sponsor is Edward D. Jones & Co., L.P. d/b/a Edward Jones.

Protected Health Information (PHI). Defined as all personally identifiable health information created or received by the “group health plan” benefit programs offered through the Plan, regardless of the way the information is stored or maintained (written, oral, or electronic).

Coordination of Benefits (COB)

If you are enrolled in another group medical plan, such as your spouse's plan, the two plans will coordinate their benefit payments, so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB). Edward Jones uses a COB method called "non-duplication of benefits." The COB provision described below applies to the medical, dental, and vision benefits offered through the Plan (collectively, the “Health Plans”).

Using COB provisions, one group health plan has "primary" responsibility and pays first. The other group health plan has "secondary" responsibility and considers any additional benefits not covered by the primary carrier. This means:

- when the health plan is ***primary***, it pays expenses as if no other health plan were involved.
- when the health plan is ***secondary***, the health plan pays benefits only if you have not already received the full amount the health plans would have paid had it been the primary plan.

When the health plan is secondary, it determines the amount it will pay for a covered medical expense by following these steps:

- The health plan determines the amount it would have paid based upon your primary plan's allowable expense (typically the In-Network rate, or the reasonable and customary charge).
- If the health plan would have paid less than the primary plan paid, the health plan pays no benefits.
- If the health plan would have paid more than the primary plan paid, the health plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

For example, if your other health plan pays an eligible expense at 80% and the Health Plans covers the same expense at 100%, you would receive an additional 20% of benefits through the firm's Health Plans. However, if the Health Plans covered that expense at 80%, you would receive no additional benefits.

Generally, this is how COB works:

If the claim is for:	Then:
You	The Edward Jones Health Plans are primary for you, as a firm associate. If you are also covered on another plan as a dependent, you can file the claim with that plan as secondary coverage.
You as a COBRA participant continuing benefits under another plan	COBRA will be primary for most circumstances. It depends on the specific circumstances. Call the Claim Administrator for more information, particularly if you or your dependent are eligible for Medicare.
Your spouse or domestic partner or your dependent children with employer coverage	The EdwardJones Health Plans are always the secondary payer if he or she is covered through another employer's medical plan
Your or your domestic partners dependent children	The primary medical plan for your dependent children is determined by the "birthday rule". For more details, see the below *COB "Birthday Rule"* section.

COB "Birthday Rule"

Under this rule, primary coverage for your or your domestic partners dependent children will be the plan of the parent whose *birthday* (not year of birth) occurs first in the calendar year. For example, if the mother's birthday is 05/23/74 and the father's birthday 07/02/73, then the mother's plan will provide primary coverage for the child since her birthday came first in the calendar year. If a decision cannot be made based on the birthday rule, the plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

- the plan of the parent with custody of the child,
- the plan of the stepparent whose spouse has custody of the child if the parent with custody has remarried, or
- the plan of the parent not having custody of the child.

Note: If a court decree declares one parent responsible for a child's health care expenses, payment will be made first under that parent's plan.

If the other group benefit program does not have a COB provision, these rules will not apply. In that case, the other group program is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

Claims Administrator's Rights

If the Plan makes larger payments than are necessary under this COB provision or under any other provision, the Plan's Claims Administrator (such as Anthem for the Medical Plan and Delta Dental for the Dental Plan) has the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made. The Claims Administrator also may pay another organization an amount that it determines is warranted if the other organization or group program pays benefits that should have been paid under the Edward Jones Plan.

The Edward Jones Health Plans also have the right to receive and release necessary information from or to any other organization or person involved in the administration of the COB provisions for the purpose of determining whether coordination of benefits or any similar provisions apply to a claim. By participating in one of these Health Plans, you have agreed to furnish any information that the Claims Administrator requires to enforce these provisions.

Integrating Medical Benefits with Medicare

Examples of When the Edward Jones Health Plans are Primary to Medicare

The Health Plans are primary for you and your covered spouse when:

- you are actively employed, but are eligible for Medicare because of your age,
- you are actively employed, but are disabled and you are eligible for Medicare as a result of your disability, or
- you are eligible for Medicare due to end-stage renal disease (ESRD), up to the time limit described in the below *Medicare Coverage for Individuals with End-Stage Renal Disease* section.

When the Health Plans are primary, benefits under your Medical Plan are determined before Medicare's benefits.

Examples of When Medicare is Primary to the Edward Jones Health Plans

Medicare is primary for you and your covered spouse when:

- your eligibility for Medicare is due to disability and you are not currently employed (and you remain on the plan because you have elected COBRA), or
- your eligibility for Medicare is due to ESRD, after the first 30 months of ESRD entitlement.

Medicare provides medical coverage for retired associates who are age 65 or older. The integration rules for persons entitled to Medicare by reason of disability or with end-stage renal disease are described below.

Medical Coverage for Disabled Individuals

If you or your eligible dependents are totally disabled, and you do not have current employment status, Medicare will provide primary medical coverage after the disabled individual receives Social Security Disability Insurance (SSDI) for 24 months. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B.

Medicare Coverage for Individuals with End-Stage Renal Disease
In all situations involving end-stage renal disease (ESRD), regardless of age or Medicare status, the Plan is the primary payer of medical expenses for the first 30 months of entitlement to Medicare because of ESRD. After the first 30 months of ESRD entitlement, Medicare is the primary payer, and the Plan is the secondary payer.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree to cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
- providing any relevant information requested by the Plan;
- signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.

- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- The Plan and all Claims Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

How to File Claims and Appeal Denials of Claims

Who can file a claim?

You may file claims for Plan benefits and appeal adverse benefit decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. Please note that the benefits offered through the Plan are personal to the recipient of the benefits and cannot be assigned. Assignments of benefits and rights under the Plan to individuals other than the covered person and/or his covered dependents shall not be recognized by the Plan. Note that the Plan will not recognize and individual or entity as your "authorized representative" if such entity or individual has a contractual or financial relationship with the applicable health care provider. Such arrangements are deemed by the Plan to be a prohibited assignment of benefits.

Filing Medical (including Wellness), Behavioral Health and Prescription Drug Claims

The process for filing a claim depends on whether you use a Network provider or an Out-of-Network provider. If you use:

- **a Network provider**, you don't have to file claims to receive benefits. The Network provider files claims for you.
- **an Out-of-Network provider**, you should:
  - Locate the appropriate Claims Administrator on the Edward Jones benefits website: www.edwardjonesbenefits.com. If you do not have access to a computer, you can call the Edward Jones HR Benefits Department and request a form.
  - print the claim form and complete your portion of the form
  - have the provider complete the provider portion of the form, and
  - send the form and itemized bills to the address shown on your ID card or on the claim form. Make sure to include the following information:
    - your name and Social Security Number,
    - the Edward Jones' name and contract number,
    - the patient's name,
    - the diagnosis,
    - the date the services or supplies were incurred, and
    - the specific services or supplies provided.

Deadline for Filing Claims
For medical, behavioral health and prescription drug claims, properly documented and submitted claims must be received by the Claims Administrator no later than the last day of the calendar year following the year the claim was incurred.

Types of Claims
Medical, behavioral health, prescription drug, and dental claims are either “pre-service”, “post-service”, “urgent care” and “concurrent care” claims. Because of Federal requirements, the appeal process is different for each. The type of your claim and their processing are described below so that you know how to appeal any denial.

Pre-Service Claims
A claim is a pre-service claim when the benefit claimed is conditioned upon providing notification or receiving approval before you receive care. If you file a pre-service claim improperly, the Claims Administrator will notify you and instruct you how to correct it within 5 days of its receipt. If you properly submit a pre-service claim to the appropriate Claim Administrator, you will receive written notice of a decision within 15 days of the Claim Administrator’s receipt of the claim. This period may be extended one time by the plan for up to 15 days if necessary due to matters beyond the control of the plan. You will be notified of any such extension prior to the end of the initial 15-day period. If an extension is necessary because additional information is needed to decide the claim, the Claim Administrator will tell you what is needed, and you will have 45 days to provide this information. If you timely provide the information, the administrator will notify you of its decision within 15 days after the information is received. If you do not timely provide the information, your claim will be denied.

Post-Service Claims
Post-service claims are claims that are filed for payment of benefits after care is provided under medical, prescription drug, and dental plans. If a post-service claim is denied under these plans, you will receive a written notice (an Explanation of Benefits) within 30 days of the Claim Administrator’s receipt of the claim. The plan may extend this period once by up to 15 days if the administrator determines such an extension is necessary due to due to matters beyond the control of the plan. The administrator will notify you within the 30-day period if an extension is necessary. If the extension is needed because you did not submit information needed to decide the claim, the notice will describe the information needed and you then have 45 days to provide this information. If you timely provide the information, the administrator will notify you of its decision within 30 days after the information is received. If you do not timely provide the information, your claim will be denied.

Urgent Care Claims
Urgent care claims are those for which applying the time periods for making non-urgent care decisions could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain.
In these situations:

- You will receive an initial notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, considering the seriousness of your condition;
- An initial notice of denial may be oral with written or with electronic confirmation to follow within 72 hours;
- If you do not provide enough information to determine whether and to what extent benefits are covered or payable under the plan, the claims administrator will notify you of the information needed to complete the claim within 24 hours after the claim was received and you then will then have a reasonable time but not less than 48 hours to provide the information; and
- You then will be notified of a determination as soon as possible but no later than 48 hours after either:
    - The Claims Administrator receives the information; or
    - The end of the period within which you were to provide the additional information.

Concurrent Care Claims
These involve cases in which a specific course of treatment or a number or length of treatments has been approved and an extension is requested. If an ongoing course of treatment was approved for a specific period or number of treatments and a request for extension is an "urgent care claim", your request will be decided as soon as possible by the claim's administrator but no later than within 24 hours after receipt, if your request is made at least 24 hours prior to the end of approved treatment. If your request for extension is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an "urgent care claim." If an ongoing course of treatment was previously approved for a specific period or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and will be decided according to post-service or pre-service time frames, whichever applies.

How to Appeal a Denied Claim for Medical, Behavioral Health & Prescriptions

Following is a general overview of the process to appeal a denied claim. Specific processes are described in each Plan section below. If a claim for benefits is denied, you may appeal that decision. Likewise, you may also appeal denials of eligibility, enrollment, termination of participation, or other issues concerning plan administrative processes. This section describes the process you must follow whenever you wish to appeal a denial of a claim for eligibility, enrollment, or issues concerning plan administration processes. Requests for review of denials of benefit claims due to clinical reasons, exclusions, or experimental treatment should be handled as specified beginning on page 9.

Discretionary Authority of Plan Administrator
Edward Jones, as Plan Administrator, has complete and exclusive discretionary authority to interpret and construe the terms of the Plan and to decide factual and other questions relating to the Plan and Plan benefits, including, without limitation, eligibility for, entitlement to and payment of benefits, to the extent such authority has not been delegated to a Claims Administrator. Any decision by the Plan Administrator is conclusive and binding. The Plan Administrator has delegated certain claims administration functions to insurers and/or other third-party administrators of the various benefit programs offered through the Plan.

Under all of the benefit plans described in this Summary Plan Description, determinations of eligibility to participate, become and remain enrolled, as well as various non-benefit determination administrative matters are made by Edward Jones.

All claims concerning denial of eligibility to participate, or time or manner of termination from participation in any plan described in this booklet as well as other matters concerning benefit administration (such as entitlement enrollment defaults, errors in participation, enrollment, COBRA eligibility or enrollment, or issues concerning the firm's automated enrollment and administration system) are handled through a process described below. Requests for review of denials of benefit claims due to clinical reasons, exclusions or experimental treatment should be handled as specified beginning on page 9.

Appeal Process if You Are Denied Eligibility or Enrollment

If are denied eligibility or enrollment, and you believe that the denial is not justified, follow the procedures stated below.

If you wish to appeal a denial of your or a dependent's eligibility to participate, termination of coverage or participation, or other administrative issues associated with your participation (other than actual denials of benefits), you may submit a written request for reconsideration to the Plan Administrator (Edward Jones Benefits Department) within 90 days after

receiving the denial. This appeal must include the reasons you think the denial was in appropriate and any other documentation that supports your position.

The Plan Administrator will review your appeal and all information submitted and will render a decision within 60 days after receipt of the request for review. If an extension of time is required, you will be notified of the reasons for the extension and the date by which the Plan Administrator expects to make a decision. The decision on review will be furnished in writing.

Appeal Process if Your Claim for Benefits is Denied - Medical and Behavioral Health

This section applies to an appeal of an adverse benefit determination. An adverse benefit determination is any denial, reduction or termination of benefits or a failure to pay a benefit. It includes a denial based on:

- clinical reasons;
- the exclusions for experimental or investigational services or unproven services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable federal law.

Requests for review of denials of eligibility or enrollment should be handled as specified in the previous section.

If your claim for benefits is denied, carefully review and follow the procedures stated below.

Time Periods for Submitting Appeals for Adverse Benefit Determinations

If you are denied a claim for benefits and you wish to appeal, you must do so within the appropriate periods described below. The specific body or person or committee with whom an appeal must be filed is stated in the *ERISA Information* section of this document. The variation in filing periods is a function of federal law. The periods for appeal are as follows:

Benefit Plan	Time for Filing 1st Level Appeal After a Benefit Denial	Response time from Claims Administrator
Medical, Behavioral Health, Prescription Drug	Within 180 days after receipt of a claim denial	• **Pre-Service** – within 15days after receipt of appeal. Medical – within 30 days after receipt of appeal. • **Post Service** – within 30 days after receipt of appeal. Medical - within 60 days after receipt of appeal. • **Urgent** – within 72 hours after receipt of appeal.

For an urgent care claim, a request for an expedited appeal may be submitted orally or in writing and all necessary information, including the decision on the appeal, shall be transmitted between you and the Claims Administrator by telephone, facsimile, or other available similarly expeditious method.

What to do first

If you have a question or concern about an adverse benefit determination, you may informally contact the applicable Claims Administrator before requesting a formal appeal. See the *ERISA Information* section for the appropriate Claims Administrator contact information. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit a formal appeal in writing.

If you disagree with a Claims Administrator's decision to deny your claim, either in whole or in part, you or your authorized representative can file an appeal with the Claims Administrator.

Requests for review of claims for benefit denials should be directed to the Claims Administrator within the time periods for submitting appeals listed in the Time Periods for Submitting Appeals in the table above.

First Level Benefit Determination Appeal Process
When an initial coverage review is denied (adverse benefit determination), a request for appeal may be submitted in writing by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. Your appeal must include:

- all information necessary to identify yourself or the patient or claimant (such as name and the identification number from the medical or other Plan ID card), the dates that medical or other services were rendered, as well as the provider's name, if applicable, the claim number and the claim denial information and any Explanation of Benefits or materials that are provided to you that documents the claim denial.
- A clear explanation of the item(s) of service, treatment or coverage that was misinterpreted or inaccurately applied and how you or a dependent has been improperly denied a benefit, eligibility or any other grievance that you wish to pursue or appeal.
- All physicians' or experts' opinions and other materials that you believe support your position and claim.

A full and fair review of all appeals will be conducted by the appropriate Claim Administrator or Plan Administrator and they will consider all comments, documents and other information that you submit.

If the appeal involves the medical or behavioral health, prescription drug, dental, employee assistance program, health savings accounts, health care flexible spending accounts, or short-term disability program, the following mandatory processes will also apply:

- The review will be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual. The review will give no deference to the initial determination.
- In any case involving medical judgment or medical necessity, the group or person performing the appeal (e.g., the Claims or Plan Administrator) will consult with a health care or other professional who has appropriate training in the field of medicine or other field involved in the area of judgment and who is neither the individual who was consulted on the claim determination nor the subordinate of such individual.
- Any experts whose advice was obtained for the determination that is being appealed will be identified to you, even if their advice was not relied upon.

Notification of Outcome of Appeal
The Claim Administrator will respond to your appeal during these timeframes:

- Pre-Service claims: within 15 days after receipt of appeal. Medical: within 30 days after receipt of appeal.
- Post-Service claims: within 30 days after receipt of appeal. Medical: within 60 days after receipt of appeal.
- Urgent claims: within 72 hours after receipt of appeal

Information to Be Provided to You on Initial Claim and Appeal Denials
If a claim for any plan benefits is denied, you will be notified in writing. Generally, any denial of eligibility or enrollment opportunity or resolution of timing of coverage termination or administrative issues will also be addressed in writing.

All decisions will be communicated in writing or electronically. Urgent care decisions may be communicated orally if written or electronic notification is provided within 72 hours after the oral notification.

Notice of an Adverse Benefit Determination on Appeal
The notice from the Claims Administrator of an adverse benefit determination on a first level appeal will contain the following information:

- the specific reason(s) for the adverse benefit determination;
- references to the specific Plan provision(s) on which the determination is based;
- statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- statement describing any second level or voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination, or a statement that such information will be provided free of charge upon request;
- if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- the following statement: *"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."*

Second Level Benefit Determination Appeal Process
If your first level appeal denial for a medical or behavioral health claim is upheld by the Claims Administrator, and you are not satisfied, you may request a Voluntary Second Level of Appeal to the Plan Administrator.

For the sake of clarity, please note that you do not need to file a voluntary appeal before requesting an Independent External Review or filing a lawsuit. If you have filed a first level appeal and received an adverse benefit determination letter from the Plan you will have been deemed to satisfy the Plan's internal Appeals Procedure and you may file a lawsuit or take other legal action of any kind against the Plan.

Non-Urgent Claims - Voluntary Second Level Appeal Option
Your second-level appeal request must be submitted in writing to the Plan Administrator within 60 days from receipt of the first level appeal decision. You must submit:

- all information necessary to identify yourself or the patient or claimant (such as name and the identification number from the medical or other Plan ID card), the dates that medical or other services were rendered, as well as the provider's name, if applicable, the claim number and the claim denial information and any Explanation of Benefits or materials that are provided to you that documents the claim denial.
- a clear explanation of the item(s) of service, treatment or coverage that was misinterpreted or inaccurately applied and how you or a dependent has been improperly denied a benefit, eligibility or any other grievance that you wish to pursue or appeal.
- all physicians' or experts' opinions and other materials that you believe support your position and claim.

If you would like to initiate a Voluntary Second Level Appeal, please send the above information to:

Edward D. Jones & Co., L.P. d/b/a Edward Jones
Benefits Department
1245 JJ Kelley Memorial Drive
St. Louis, MO 63131
Phone: (314) 515-2000

If you are appealing a pre-service first-level appeal denial, the Plan Administrator will notify you of the decision on a pre-service second-level appeal within 15 days from receipt of a request for review. If you are appealing a post-service first-level appeal denial, the Plan Administrator will notify you of a decision within 30 days. See Types of Claim Appeals for details on the process and timing required for submitting pre-service and post service claims.

All voluntary appeals will be administered consistently with the ERISA Benefit Claims Procedure Regulations. You are not required to file a voluntary appeal as part of exhausting the Plan's internal Appeal Procedures.

Non-Urgent Claims - Independent External Review Option
If you are not satisfied after exhausting your first or second level appeals, you may request an Independent External Review. As noted above, Edward Jones also offers a special Voluntary Second-Level of Appeal to the Plan Administrator. If you choose to pursue a Voluntary Second-Level of Appeal to the Plan Administrator, you can file an Independent External Review after that level of appeal is completed. However, please note that you do not have to first submit a Voluntary Second-Level Appeal to the Plan Administrator to request an Independent External Review. An Independent External Review is available only for an adverse benefit determination that involves medical judgment or that involves a rescission of coverage.

The process is available at no charge to you after exhausting the first level appeal process identified above, after you have received a denial on the voluntary second level review or if the Claim Administrator fails to respond to your appeal in accordance with applicable regulations. If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claim Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by sending a written

request to the appropriate Claim Administrator as noted your Explanation of Benefits for the claim with the adverse benefit decision.

To perform this appeal, you should resubmit the information submitted with the original claim plus any and all information that responds to and addresses the grounds for the decision in the final appeal and any new information that supports your position. Within five days of the request, the Claim Administrator will conduct a preliminary review to ensure that (a) you were appropriately covered when the medical service was provided and (b) the claim does not relate to eligibility to participate or obtain coverage or the services do not require a medical judgment, (c) you have exhausted all required appeal processes, and (d) you have provided all relevant information to process a claim. Within 24 hours following this preliminary review, the Claim Administrator will issue a notification in writing to you. If the request is eligible for an independent external review, the Claim Administrator will assign an Independent Review Organization (IRO) to conduct the review.

If the request is not complete and can be perfected in order for an Independent External Review to be filed, you will be provided the later of 48 hours from receipt of the Claim Administrator's response or the remainder of the four-month period in which to cure the request. If the request is proper, the Claim Administrator will submit all materials considered in the matter to the IRO. The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO, within ten (10) business days following the date of receipt of the notice, additional information for the IRO to consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. The Independent External Review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the plan. The Independent Review Organization (IRO) has been contracted by the Claim Administrator and has no material affiliation or interest with the Claim Administrator or the Plan Administrator (Edward Jones). The Claim Administrator will choose the IRO based on a rotating list of appropriately accredited IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Claim Administrator's receipt of a request for independent external review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by the Claim Administrator in making a decision on the case; and
- all other information or evidence that you or your physician has already submitted to the Claim Administrator.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claim Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claim Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law. If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claim Administrator at the toll-free number on your ID card for more information regarding your Independent External Review appeal rights and the review process.

Urgent Care Claims – Voluntary Second Level Appeal
If you have an urgent care medical or behavioral health claim denial that is upheld, and you are not satisfied, you may request a second level review through the Claims Administrator. You may also request an Independent External Review after completing the Voluntary Second Level Appeal (described above), but you are not required to complete that voluntary level before requesting Independent External Review.

Your urgent care voluntary second level appeal need not be submitted in writing. You or your physician should call the Claim Administrator as soon as possible. The Claim Administrator will provide you with a written or electronic determination as soon as possible but no more than 72 hours following receipt of your request for review. For urgent claim

appeals, the Claim Administrator has the exclusive right to interpret and administer the provisions of the plan. Its decisions are the final internal review.

Urgent Care Claims - Independent External Review
If your first level appeal of an urgent care claim is upheld (denied), you may request an independent external review. If you wish to have an external review, you should request it in the same manner as requesting an external appeal for non-urgent claims by submitting your request to the Claim Administrator. Immediately upon receipt of your request, the Claim Administrator will conduct a preliminary, but very expedited, review like that described above for non-urgent claims, and will promptly send you a notice of whether the claim is eligible for external review or advise you immediately of any deficiencies that can be cured.

If the claim is eligible for review, the Claim Administrator will assign the matter to an IRO and will provide to the assigned Independent Review Organization ("IRO") the documents and information considered in making its determination. The documents include: (1) all relevant medical records; (2) all other documents relied upon by the Claim Administrator; and (3) all other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your independent external review request and the Claim Administrator will include it with the documents forwarded to the IRO. The IRO will render a decision as soon as feasible but in no event more than 72 hours after the IRO receives the approved request for review.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced within two years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. Since your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA. The legal action must be brought in a federal district court sitting within the Eastern District of Missouri within two years of the date of the final denial of your appeal.

For the sake of clarity, please note that you do not need to file a voluntary appeal before filing a lawsuit. You do not need to file an appeal with an Independent External Review appeal before filing a lawsuit. If you have filed a first level appeal and received an adverse benefit determination letter from the Plan you will have been deemed to satisfy the Plan's internal Appeals Procedure and you may file a lawsuit or take other legal action of any kind against the Plan.

Prescription Coverage Review and Appeal Process

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization or have quantity limits. For the process to request reviews of enrollment, eligibility, or other administrative issues, please see page 8.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review: To request an initial clinical coverage review, the prescriber or dispensing pharmacist should submit the request electronically. Information about electronic options can be found at express-scripts.com/PA or by calling the Express Scripts Coverage Review Department at 1 800-753-2851. Home Delivery coverage review requests are automatically started by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on

the back of your prescription card. Complete the form and fax it to 1-877-328-9660 or mail to Express Scripts, Attn: Benefit Coverage Review Department, P.O. Box 66587, St. Louis, MO 63166-6587.

If the claim is an urgent care claim, an expedited review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. The expedited review must be requested by phone at 1 800-753-2851.

How an initial coverage review is processed: In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of prescription claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request but no later than:**	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days, or the claim will be denied.

First Level Appeal Process
When an initial coverage review is denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the clinical appeals department:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

The above information should be faxed or mailed to the appropriate department: Express Scripts Clinical Appeals Department fax 1-877-852-4070. Alternatively, information may be mailed to: Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St. Louis, MO, 63166-6588.

Administrative Appeal Requests: Express Scripts Administrative Appeals Department fax 1-877-328-9660 or mailed to Express Scripts, Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO 63166-6587.
An urgent appeal may be submitted if, in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent clinical appeals must be submitted by phone by calling 1-800-753-2851 or via fax 1-877- 852-4070.
Urgent administrative appeals by phone 1-800-946-3979 or via fax 1-877-328-9660.

How a first level appeal or urgent appeal is processed
Express Scripts completes appeals in accordance with business policies that are aligned with federal regulations. Depending on the type of appeal, appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of prescription claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request but no later than:**	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

Second Level Appeal Process
When a first level benefit appeal has been denied (adverse benefit determination), a request for a second level appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the first level appeal adverse benefit determination.

To initiate a second level appeal, the following information must be submitted by mail or fax to the appropriate Express-Scripts department for clinical or administrative review:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills, or any other documents

The above information should be faxed to the Express Scripts Clinical Appeals Department at 1-877-852-4070. Alternatively, you may mail the information to Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St. Louis, MO, 63166-6588.

Administrative Appeal Requests: Express Scripts Administrative Appeals Requests fax 1-877-328-9660 or via mail: Express Scripts, Attn: Administrative Appeals Department, PO Box 66587, St. Louis, MO, 63166-6587.

An urgent second level appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy, or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Express Scripts does not accept non-urgent appeals verbally. Inquiry calls can be made but requests for non-urgent appeals must be made in writing.

- Urgent clinical appeal requests, by phone 1-800-753-2851 or via fax 1-877-852-4070
- Urgent administrative appeals requests, by phone 1-800-946-3979 or via fax 1-877-328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a second level appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request but no later than:**	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

Voluntary Level of Appeal Option:

If you are not satisfied with the response after exhausting your first and second level of appeals with Express Scripts, you may request a voluntary level of appeal by writing to the Plan Administrator (Edward Jones) within 60 days from receipt of the second level appeal decision. You must submit:

- all information necessary to identify yourself or the patient or claimant (such as name and the identification number from the Plan ID card), the dates that prescription was requested and/or filled, as well as the provider's name, if applicable.
- the claim number and the claim denial information and any Explanation of Benefits or materials that are provided to you that documents the claim denial.

- a clear explanation of the item(s) of service, treatment or coverage that was misinterpreted or inaccurately applied and how you or a dependent has been improperly denied a benefit, eligibility, or any other grievance that you wish to pursue or appeal.
- all physicians' or experts' opinions and other materials that you believe support your position and claim.

If you would like to initiate a voluntary level appeal, please send the above information to:

Edward D. Jones & Co., L.P. d/b/a Edward Jones
Benefits Department
1245 JJ Kelly Memorial Drive
St. Louis, MO 63131
Phone: (314) 515-2000

The Plan Administrator will notify you of the decision on a pre-service voluntary level of appeal in 15 days from receipt of your request for review. If you are appealing a post-service appeal denial, the Plan Administrator will notify you of a decision within 30 days.

Independent External Review Option:
If you are not satisfied after exhausting your first and second level of appeals for non-urgent claims or the first level appeal for an urgent claim with Express Scripts, or after your voluntary appeal to the Plan Administrator, you may request an Independent External Review. The right to request an Independent External Review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. The external review will be conducted by an Independent Review Organization (IRO) with medical experts that were not involved in the prior determination of the claim. The external review must be requested within 4 months of the date of the second level appeal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

To submit an Independent External Review, the request must be mailed or faxed to:

MCMC LLC Attn: Express Scripts Appeal Program
300 Crown Colony Drive
Suite 203,
Quincy, MA 02169-0929
Fax: 1 617- 375- 7683
Phone: 1 617- 375- 7700 ext. 28253

How an Independent External Review is processed
Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO). You will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the claim's administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send you, the Plan Administrator, and the Claim Administrator written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an

IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send you written notice of its decision.

The decision of the IRO is final and binding and will exhaust any further appeal rights.

How to Appeal a Denied Nicotine Replacement Therapy Claim (for those not enrolled in the medical plan)
If your claim to be reimbursed for nicotine replacement therapy is denied either in whole or in part, you will receive written notification from the claims administrator.

You or an authorized representative may file a written appeal within 180 days after you receive the written notice of denial. Your written appeal must be submitted to Anthem. Make sure to include copies of documents or records that support your appeal. You may also review documents related to the EAP administration and submit written comments outlining the basis of the appeal. Submit your appeal to:

Anthem Blue Cross Blue Shield
P.O Box 54159
Los Angeles, CA 90054-0159
Phone: (800) 359-0640

Anthem will review the appeal and render a decision within 60 days after they receive the request for review. In unusual situations, an additional 30 days may be needed. You will be notified of this in writing during the first 60-day period.

If your claim is denied, you will receive a written explanation from Anthem that includes the information described above and you will have the right to file a civil claim under ERISA to challenge the denial. Any civil action must be filed within two years after the date of the final denial.

If you have questions about filing a claim or to the review procedure, call Anthem at 800-359-0640.

Filing an EAP Claim

The process for claims payment depends on whether you use a Mental Health/Substance Abuse counselor or a Tobacco Cessation coach.

If you use a:

- Mental Health/Substance Abuse counselor call Anthem for claims; or
- Tobacco Cessation coach, call Virgin Pulse if you are enrolled in an Edward Jones medical plan. Anthem

Anthem Blue Cross Blue Shield P.O Box 54159 Los Angeles, CA 90054-0159 Phone: (800) 359-0640Anthem	Virgin Pulse http://join.virginpulse.com/EdwardJones 833-880-4209; Monday-Friday 8:00 a.m.-9:00p.m. EST

Appealing a Denied EAP Claim

If your claim is denied, either in whole or in part, you will receive written notification from the claims administrator.

You or an authorized representative may file a written appeal within 180 days after you receive the written notice of denial. Your written appeal must be submitted to the Appeals Committee for EAP. Make sure to include copies of documents or records that support your appeal. You may also review documents related to the EAP administration and submit written comments outlining the basis of the appeal. Submit your appeal to: Anthem

Anthem Blue Cross Blue Shield
P.O Box 54159
Los Angeles, CA 90054-0159
Phone: (800) 359-0640.

The EAP will review the appeal and render a decision within 60 days after they receive the request for review. In unusual situations, an additional 30 days may be needed. You will be notified of this in writing during the first 60-day period.

If your claim is denied, you will receive a written explanation from the EAP that includes the information described above and you will have the right to file a civil claim under ERISA to challenge the denial. Any civil action must be filed within two years after the date of the final denial.

If you have questions about filing a claim or the review procedure, call the EAP.

Filing a Claim under the HMSA Plan (Hawaii Residents Only)

When to File Claims: All participating and most nonparticipating providers in Hawaii will file claims for you. If your nonparticipating provider doesn't file claims for you, please submit an itemized bill or receipt within 90 days of the last day on which you received services. No payment will be made on any claim received by us more than one year after the last day on which you received services.

How to File a Claim: File a separate claim for each covered family member and each provider. You should follow the same procedure for filing a claim for services received in Hawaii, out of state, or outside the U.S.

Information You Must Submit:

- The subscriber number that appears on your HMSA membership card.
- The bill or statement from your provider itemizing all services provided. Statements you prepare yourself, cash register receipts, receipt of payment notices, and balance due notices cannot be accepted. Without the provider statement, claims are not eligible for benefits.

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or beginning of illness.
- Charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other health coverage you may have.

It is helpful if the provider statement is on the provider's stationery and is in English or accompanied by the English translation. Please include a daytime phone number where you can be reached. Make sure you sign the claim and enclose proof of payment.

Send your claim to:

HMSA
P.O. Box 860
Honolulu, HI 96808-0860

Appealing a Denied HMSA Claim

If you disagree with a decision HMSA has made about your plan coverage, reimbursements to you or your doctor, or other decisions, you can file an appeal with HMSA to review the decision.

Print out the form found at https://hmsa.com/help-center/forms/member-appeal/ and print clearly in all fields. Mail or fax the completed form to:

HMSA Member Advocacy & Appeals
P.O. Box 1958
Honolulu, HI 96805-1958
Fax: 808-952-7546 or 808-948-8206 on Oahu

You can also email your appeal to appeals@hmsa.com, however, please note that unencrypted email could be intercepted. If you don't want to take this risk, please fax or mail your appeal.

Standard appeal: After we receive your appeal request, we'll respond within 30 days if it's for a service you haven't yet received. We'll respond within 60 days if your appeal is for a service you've already received. Refer to your Evidence of Coverage or Guide to Benefits for details about the standard appeal process.

Fast appeal: You can request a fast appeal if your health is in jeopardy. We'll notify you by telephone and in writing of our decision within 72 hours. Refer to your Evidence of Coverage or Guide to Benefits for details about the fast appeal process.

Filing a Dental Claim

The process for claims payment depends on whether you use a dentist who participates in the Delta Dental Plan or a non-participating dentist.

If you use a:

- **Delta Dental participating dentist** and present your dental ID card, you don't have to file a claim to receive benefits. The dentist will file your claim for you, and Delta Dental will pay the dentist directly for the covered expenses. Then the dentist will bill you for your portion, if any. This amount is shown on the Explanation of Benefits (EOB) that Delta Dental will provide.
- **Non-participating dentist,** you pay the dentist directly and then submit claims for reimbursement to Delta Dental. Benefits for covered expenses are paid directly to you after a claim for a completed dental procedure has been filed and processed. Claim forms are available on JonesLink, or from the Edward Jones Benefits Department.

You must file your claim by the last day of the calendar year following the year in which services were rendered.

- **If your claim is approved** payment will be made as soon as Delta Dental receives and approves all necessary documentation.
- **If your claim is denied** you will receive a written explanation from Delta Dental that includes:
    - specific reasons for the denial,
    - reference to the Dental Plan provisions on which the denial is based,
    - description of any additional information you may have to provide and why it's needed,
    - an explanation of the Dental Plan's claim review procedure, including your right to bring a civil action under ERISA after an adverse decision on appeal, or
    - if the denial is based on medical necessity, experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the denial or a statement that the explanation will be provided free of charge upon request.

Appealing a Denied Dental Claim

If your claim is denied, either in whole or in part, you will receive written notification from Delta Dental.

You or an authorized representative may file a written appeal within 180 days after you receive the written notice of denial. Your written appeal must be submitted to the Appeals Committee for Delta Dental. Make sure to include copies of documents or records that support your appeal. You may also review documents related to Dental Plan administration and submit written comments outlining the basis of the appeal. Submit your appeal to:

Delta Dental of Missouri
Appeals Committee
12399 Gravois Rd.
St. Louis, Missouri 63127-1702

Delta Dental will review the appeal and render a decision within 30 days after they receive the request for review. In unusual situations, an additional 30 days may be needed. You will be notified of this in writing during the first 30-day period.

If your claim is denied, you will receive a written explanation from Delta Dental that includes the information described above and you will have the right to file a second appeal with the Plan Administrator. A second level of appeal must be submitted in writing within 60 days after you receive notification of the decision on the first level of appeal. As with the first level of appeal, you should submit any additional information or documentation that you would like to have considered as part of the second level of appeal. You may also request copies from the Claims Administrator, free of charge, of all documents, records and other information relevant to your appeal. As with the first level of appeal, you will be notified of the decision, in writing, not later than 15 days (for pre-service requests), 30 days (for post-service claims) after the appeal is received.

If your denied claim is not approved, you may file a civil claim under ERISA to challenge the denial. Any civil action must be filed within two years after the date of the final denial.

Filing a Vision Claim

The process for claims payment depends on whether you use a VSP Network Provider who participates in the VSP Vision Plan or a Non-VSP Network Provider.

If you use a:

- **Participating VSP Network Provider,** tell the VSP network eye-care provider that you are a VSP member when making your appointment. The VSP Network Provider files your claim for you, and VSP pays the VSP Network Provider directly for the covered expenses. Then the VSP Network Provider subsequently bills you for your portion, if any.
- **Non-VSP Network Provider,** you pay the eye-care provider directly and then submit claims for reimbursement to VSP. Benefits for covered expenses are paid directly to you after a claim for a completed vision procedure has been filed and processed. Claim forms are available by contacting VSP.

To ensure a timely reimbursement, log in to www.vsp.com and access the online Out-of-Network Reimbursement Form on the ""Benefits" page or send the following information to VSP:

- an itemized receipt listing the services you received,
- the name, address, and phone number of the non-VSP provider,
- the covered member's name, phone number and address,
- the name of the organization that provides your VSP coverage,
- the patient's name, date of birth, phone number and address, and
- the patient's relationship to the covered member (such as "self," "spouse," "child").

All claims for reimbursement must be submitted within 24 months of the date of service. Participants should keep a copy of the information for their records and send the originals to:

VSP
Attn: Out-of-Network Claims
P.O. Box 385018
Birmingham, AL 35238-5018

VSP makes the decision to approve or deny your claim:

- **If your claim is approved**, payments are made as soon as VSP receives and approves all necessary documentation.
- **If your claim is denied**, you will receive a written explanation from VSP that includes:
  - specific reasons for the denial,
  - reference to the plan provisions on which the denial is based,
  - description of any additional information you may have to provide and why it's needed, and
  - an explanation of the plan's claim review procedure including your right to bring a civil action under ERISA after an adverse decision on appeal.

Appealing a Denied Vision Claim

If your claim is denied, either in whole or in part, you will receive written notification from VSP.

You or an authorized representative may file a written appeal within 180 days after you receive the written notice of denial. Your written appeal must be submitted to the Appeals Committee for VSP. Make sure to include copies of documents or records that support your appeal. You may also review documents related to Vision Plan administration and submit written comments outlining the basis of the appeal. Submit your appeal to:

VSP
Appeals Committee
3333 Quality Drive
Rancho Cordova, California 95670.
1-800-877-7195

VSP will review the appeal and render a decision within 60 days after they receive the request for review. In unusual situations, an additional 30 days may be needed. You will be notified of this in writing during the first 60-day period.

If your claim is denied, you will receive a written explanation from VSP that includes the information described above and you will have the right to file a civil claim under ERISA to challenge the denial. Any civil action must be filed within two years after the date of the final denial.

If you have questions about filing a claim or the review procedure, call VSP at **1-800-877-7195**.

Filing a Disability Claim

This section describes the claims benefit determination process for the Short-Term Disability (*STD*) and Long-Term Disability (*LTD*) Plan provided under the Plan.

Claims must be submitted within 90 days of the date of loss, or as soon as is reasonably possible. Written proof of disability must be provided within one year unless you are legally incapacitated.

Unless special circumstances require an extension of time for processing your claim, the Claims Administrator of the *STD plan* (MetLife) or *LTD plan* MetLife) will mail notice of their decision within 45 days after receipt of the claim. If an extension is necessary, you will be given written notice of the required extension before the end of the initial 30 day period. This 30 day time period may be extended up to an additional 30 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 45-day period. If another extension is necessary, you will be notified before the end of the initial 30 day extension period. This second extension period may not be longer than 30 days. Any extension notices provided pursuant to this paragraph will tell you why there was an extension, when the Claims Administrator expects to make a decision, the standards on which entitlement to a benefit is based, the unresolved issue(s) that prevent a decision on the claim and the additional information needed to resolve the issue(s).

Notice of an Adverse Disability Claim Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- the specific reason(s) for the adverse benefit determination,
- references to the specific plan provision(s) on which the determination is based,
- a description of any additional material or information needed to process the claim and an explanation of why such information is necessary, and
- a description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.

Appealing a Denied Disability Claim

If your *STD* or *LTD* claim is denied, you will receive written notification of this decision from the Claims Administrator.). If you and your doctor do not agree with the Claim Administrator's decision, you have the right to appeal or ask for a review of the decision in writing within 180 days. Here's the process to appeal a decision:

1. You must request, in writing, a review of the decision within 180 days if the claim will require the Claims Administrator to make a determination of disability.
2. You must mail a letter requesting a review to the Claims Administrator:

   MetLife Disability Appeals Department
   P.O. Box 14592
   Lexington, KY 40512

You may request, free of charge, copies of all documents, records and other information relevant to your claim and you may submit written comments, documents, records and other information relating to your claim.

The Claims Administrator will respond to you in writing regarding their final decision on the claim within 45 days after the appeal is received. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, The Claims Administrator (notifies you in writing that an extension is necessary due to matters beyond the control of the Administrator, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Claims Administrator receives your response to our request. If the Administrator approves your claim, the decision will contain sufficient information to reasonably inform you of that decision.

If your appeal is denied, the denial notice will include:

1. the specific reason or reasons for the decision;
2. specific references to the Policy provisions on which the decision is based;
3. a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. a description of the Insurance Company's review procedures and time limits applicable to such procedures;
5. a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal;
6. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you,
    b. the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
    c. a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration;
7. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist;
9. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
10. a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appeals will be conducted by an appropriate fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor a subordinate of such individual. Each level of review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether such information was submitted or considered in the prior levels of review and will not afford deference to the prior adverse benefit determinations. If your appeal involves a decision that was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal or a subordinate of such individual. If the Claims Administrator obtained the advice of any medical or vocational expert in connection with your appeal, the decision on review will provide for the identification of such experts, regardless of whether the Claims Administrator relied on the advice in making the benefit determination.

Filing a Life and AD&D Insurance Claim

Benefits will be paid to you or your beneficiary(ies) if you or your eligible dependents receive covered injuries or die while covered by an Edward Jones Life and Accidental Death & Dismemberment Insurance Plan. The insurance company must first certify the loss before you or your beneficiary(ies) are eligible to receive a benefit payment. For certification you or your beneficiary(ies) must submit a claim and provide conclusive proof of the covered loss (see the *ERISA Information* section for the insurance company's contact information).

Once a claim is submitted, the insurance company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the insurance company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision.

If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the insurance company receives your response to its request. If the insurance company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

The insurance company will communicate with you once it makes a decision to approve or deny your claim. If your claim is approved, you or your beneficiary will receive all applicable benefits as soon as the insurance company receives and approves all necessary documentation. If your claim is denied, denied, you or your beneficiary will receive a written explanation from the insurance company within 90 days (or 180 days if there was an extension) that includes:

- specific reasons for the denial,
- specific reference to the policy provisions on which the denial is based, and
- notice of your right to bring a civil action under section 502(a) of ERISA after you appeal the insurance company's decision and you receive a written denial on appeal (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing a Denied Life and AD&D Insurance Claim

You, your beneficiary or an authorized representative may appeal any claim denial by filing a written request for a full and fair review with the appropriate insurance company. You may also review documents pertinent to the administration of the Plan and submit written comments and issues outlining the basis of the appeal. You may have legal representation throughout the review procedure.

Claim Appeal:
On any claim, the claimant or his or her representative may appeal to the insurance company for a full and fair review. To do so, he or she:

1. must request a review upon written application within:
    a. 180 days of receipt of claim denial if the claim requires the insurance company to make a determination of disability, or
    b. 45 days of receipt of claim denial if the claim does not require the insurance company to make a determination of disability, and
2. may request copies of all documents, records, and other information relevant to the claim, and
3. may submit written comments, documents, records and other information relating to the claim.

The insurance company will respond in writing with their final decision on the claim.

Filing an HSA or FSA Reimbursement Claim

When you incur an eligible expense for your HSA or FSA, you can use the provided debit card to pay the bill. Alternatively, you may pay the bill directly to the provider using other means and submit a claim for reimbursement to the Claims Administrator of the HSA and FSA Program, HealthEquity. You may submit claims for reimbursement for your eligible expenses at any time during the year. For HSA claims, you may submit a claim for any date of service incurred after you established your HSA account. For FSA claims, you may submit claims only for expenses incurred during the period which you were contributing to your FSA account and must file your claim by March 31st of the following year.

To file a claim for reimbursement from your account(s) or on the HealthEquity mobile app.

- visit www.MyHealthEquity.com to file a claim.
- if your claim is to be paid from your Health Care, Dental/Vision FSA, or Dependent Care FSA, the Internal Revenue Service requires that you provide substantiation that the expense is eligible. You will be required to include the documentation listed below:
    - **For covered health care services** include itemized receipts from the service provider and Explanation of Benefits (EOB) forms. Canceled checks and credit card charge receipts are not acceptable forms of documentation for this account. Itemized receipts must contain the:
        - date of service or purchase,
        - type of service or name of product,
        - amount (Paid by you), and
        - name of person or organization providing the service or product.
    - **For covered dependent care services** include itemized receipts of your dependent care expenses or signed provider affidavit on the claim form for each expense. Cancelled checks or payment statements are not acceptable forms of documentation for this account. Itemized receipts must contain the:

- name and address of the care provider,
- Tax ID Number or Social Security Number of the care provider,
- date of services for which you're being charged, and
- amount you're being charged.

Note: All documentation for covered health care services and for covered dependent care services must be retrospective; prepaid bills for claims submitted before the period of care are not acceptable.

Fax or upload the completed form and all documentation to the fax number provided on the HealthEquity website or mail the completed claim form and all documentation to the address shown on the claim form.

How Requests are Paid
Claims for reimbursement are processed and distributed daily. You may file a claim for reimbursement from your Health Care and Dependent Care FSA(s) at any time. You have until March 31, 2023, to file a claim for eligible expenses you have incurred between January 1, 2021, and December 31, 2021. Claims received after March 31, 2023, will not be reimbursed and remaining funds will be forfeited to the plan.

Dependent Care claims are not payable until after the service period is complete. For example, if you pay preschool fees for the month of March on March 1st, to cover the period March 1 through March 31st, the reimbursement will not be paid from your account until April 1st.

If your claim is approved, you will receive a reimbursement check in the mail, or you can sign up for direct deposit to your preferred bank account. Direct deposit is the recommended method for speeding the reimbursement funding process.

Appealing an HSA or FSA Reimbursement Request Denial

If part or all of your claim is denied, HealthEquity will provide you with written notice of this denial within 30 days of receipt of your claim. The denial must state:

- the reason(s) for the denial,
- a description of any additional materials needed to re-submit the claim and why it is needed, and
- the appropriate steps to be taken in order to obtain a review of the decision.

In special cases, HealthEquity may take another 15 days to process the claim. If this is the case, Health Equity must notify you of the reason(s) for the delay.

You may appeal a denied claim by writing to Health Equity within 180 days after the claim payment date or the date of denial, whichever is later. Your appeal must include the claim number of the denied claim and the reasons you believe the denial was incorrect. You may submit additional information to support your appeal. Mail the appeal to:

HealthEquity
Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 100
Draper, UT 84020

You will receive a response within 30 days.

If your appeal is denied, you will receive a written explanation from the claims administrator that describes your right to file a civil claim under ERISA to challenge the denial. Any civil action must be filed within two years after the date of the final denial.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice applies to the group health plan benefit programs offered through the Edward D. Jones & Co. Employee Health & Welfare Program. Please review this Notice carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list ("accounting") of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for an additional copy of this notice at any time. We will provide you with a paper copy promptly. • This Notice will also be available on the Edward Jones benefits intranet.
Choose someone to act for you	• If you have given someone a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you what us to do, and we'll follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.	***Example:*** We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. *Visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html for more information.*

Help with public health and safety issues	• We can share health information about you for certain situations, such as:
	  ○ Preventing disease
	  ○ Helping with product recalls
	  ○ Reporting adverse reactions to medications
	  ○ Reporting suspected abuse, neglect, or domestic violence
	  ○ Preventing or reducing a serious threat or anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  ○ For workers' compensation claims
	  ○ For law enforcement purposes or with a law enforcement official
	  ○ With health oversight agencies for activities authorized by law
	  ○ For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will provide a copy to you. This notice is effective as of January 1, 2015.

Contact Information

Please contact the Privacy Officer if you have any questions about this Notice. The Privacy Officer can be reached at:

Protected Health Information Manager
Edward Jones, HR Benefits Department
1245 J.J. Kelley Memorial Drive
St. Louis, MO 63131

ERISA INFORMATION

This section contains important administrative information about the benefits provided to you by Edward D. Jones & Co., L.P. d/b/a Edward Jones. The information applies to all your benefits and includes details about your rights as provided under the Employee Retirement Income Security Act of 1974 ("ERISA").

Although ERISA does not require an employer to provide benefits, it does set standards on how a plan is run. It also requires that you be kept fully informed of your rights and benefits, the details of which are included in this handbook.

Plan Sponsor and Administrator

Edward Jones sponsors the Plan described in this handbook. The firm also controls and manages the operation and administration of these benefits in its role as Plan Administrator under ERISA. If you have a question, the Plan Sponsor and Administrator are located at:

Edward D. Jones & Co., L.P. d/b/a Edward Jones
Benefits Department
1245 JJ Kelley Memorial Drive
St. Louis, MO 63131
Phone: (314) 515-2000

The Plan Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Plan Sponsor and Administrator's Number

The employer identification number for Edward D. Jones & Co., L.P. is 43-0345811.

Agent for Legal Process and Legal Action Timeframe

If you need to take legal action with regard to one of these plans, legal process may be served on the firm at the above address. Action must be taken within two years of the date your benefit was denied (or the date your cause of action first arose, if earlier).

The Future of the Plans

Edward Jones intends to continue these plans at this time. However, the firm reserves the right to amend, modify or terminate the plans, in whole or in part, at any time for any reason.

If the plans are amended or terminated, you and other active associates may not receive benefits as described in this SPD. However, you may be entitled to receive different benefits, or benefits under different conditions. You will be notified, in writing, of any change.

Plan Facts

ERISA requires that the firm disclose specific facts about your benefits, including Plan types, Plan numbers, names and addresses of the insurers or administrators for the Plans, and how each Plan is funded. You will find these administrative facts in the table below and in the charts under the *Insured Plan* and *Self-Insured Plan* sections.

The Edward D. Jones & Co. Employee Health & Welfare Program (the "Plan") is an employer-sponsored welfare benefit plan. Its legal plan number is 501. The Plan is administered on a calendar year basis. The following chart outlines the various benefit programs offered through the Plan. Not all benefit programs are subject to ERISA.

Plan Name	Source of Funding
Edward Jones Medical Plan	Self-insured. Edward Jones and you share in the cost of coverage
Edward Jones Dental Plan	Self-insured. You are fully responsible for the cost of coverage.
Edward Jones Vision Plan	Self-insured. You are fully responsible for the cost of coverage.
Edward D. Jones & Co. Medical Reimbursement Plan (Health Care Flexible Spending Accounts) Edward Jones Health Savings Accounts	Self-funded. The FSAs are funded by your pre-tax contributions. The HSA is funded by your contributions and, in some cases, employer contributions.
Edward Jones Short-Term Disability Plan Edward Jones Long-Term Disability Plan	Long-term disability is fully-insured; short-term disability is self-insured. Cost-sharing varies by participant status.
Edward Jones Employee Assistance Program	Fully-insured. Edward Jones pays the cost of coverage.
Edward Jones Basic Life Insurance Plan Edward Jones FA Survivor Benefit Edward Jones Basic Accidental Death and Dismemberment (AD&D) Insurance Plan	Fully-insured. Edward Jones pays the cost of coverage
Edward Jones Supplemental Life Insurance Plan Edward Jones Dependent Life Insurance Plan Edward Jones Supplemental Accidental Death and Dismemberment Insurance Plan Edward Jones Family Accidental Death and Dismemberment Insurance Plan	Fully-insured. You pay the cost of coverage

Claims Filing Information

Insured Plans

The following plans are insured through contracts with insurance companies who insure and administer claims for these plans and are solely responsible for providing benefits.

Insured Plan	Insurance Company
Basic Life Insurance Dependent Life Insurance Supplemental Life Insurance Plan FA Survivor Benefit Plan	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505
Basic AD&D Insurance Plan Supplemental AD&D Insurance Plan	Zurich North America Commercial Claims Claims Department, Zurich American Insurance Company P.O. Box 968041 Schaumburg, IL 60196-8041 Toll free number: (866) 841-4771 Dedicated Claim Fax: (866) 255-2962
Long Term Disability Plan	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505

Self-Insured Plans

The following plans are self-insured by the firm through contributions made solely by the firm, by participating associates, or contributions made jointly by the firm and participating associates. As of the date of this SPD, Medical, Dental and Vision Plan contributions are held in the general assets of Edward D. Jones & Co., L.P. for payment by the Claims Administrator for each plan.

Claims must be submitted to and approved by the appropriate Claims Administrator before any benefit payments can be made. See the *Claims and Appeals* section of this document for details on submitting and appealing claims.

The firm has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured plans.

Self-Insured Plan	Claims Administrator
Medical Plan	
Medical and Behavioral Health Benefits and Employee Assistance Program	Anthem Blue Cross Blue Shield P.O Box 54159 Los Angeles, CA 90054-0159 Phone: (800) 359-0640
Prescription Benefits	Express-Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417 Phone: (201) 269-3400
Wellness Program	Virgin Pulse 75 Fountain Street Providence, RI 02902 Phone: (833) 880-4209
Dental Plan	Delta Dental of Missouri PO Box 8690 St. Louis, MO 63126 Phone: (800) 335-8266
Vision Plan	Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 Phone: 1-800-877-7195

Self-Insured Plan	Claims Administrator
Medical Plan	
Medical and Behavioral Health Benefits and Employee Assistance Program	Anthem Blue Cross Blue Shield P.O Box 54159 Los Angeles, CA 90054-0159 Phone: (800) 359-0640
Prescription Benefits	Express-Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417 Phone: (201) 269-3400
Wellness Program	Virgin Pulse 75 Fountain Street Providence, RI 02902 Phone: (833) 880-4209
Reimbursement Accounts Health Care Reimbursement Account (*also known as, "Health Care FSA")* Health Savings Account	HealthEquity 15 Scenic Pointe Dr, Ste 100 Draper, UT 84020 844-281-0433

Your Rights Under ERISA

As a participant in the Edward Jones Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to the following rights:

Receive Information about Your Plan and Benefits

- You may examine, free of charge, all documents governing the Plan including insurance contracts, collective bargaining agreements, and the latest annual report (Form 5500 Series). These documents are available at the Plan Administrator's office and at other specified locations. The annual report also is filed with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- You may also receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Coverage

- You may continue medical, dental or vision coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the *Leaving the Plan* section of this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for operating the Plan. These people are called "fiduciaries" of the Plan. They have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.
- No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you are otherwise entitled or from exercising your rights under ERISA.

Enforcement of Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, the Plan Administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to have the Plan Administrator review and reconsider your claim, all within certain defined time schedules.
- Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision, concerning the qualified status of a domestic relations order or medical child support order. If Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court; provided you have first exhausted the appeals procedure set forth in this summary plan document.
- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), it may order you to pay these costs and fees.

Assistance with Your Questions

- If you have any questions about a Plan, you should contact the Edward Jones Benefits Department or the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact:

  Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue NW
  Washington D.C. 20210

- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.