Medical, Prescription and Behavioral Health Benefits For FAs, GPs, SPs, BOAs, and Home Office Associates

This section of the Summary Plan Description (SPD) does not apply to residents of Hawaii, who are offered HMSA medical coverage instead of the coverage described in this section. If you live in Hawaii, please refer to the HMSA coverage guide found on the HMSA member website to learn more about the benefits offered through the HMSA program. If you want to file a claim for benefits under the HMSA program, please view the "Claim, Appeal, and Legal Information" of this SPD. Contact the Edward Jones Benefits Department if you have questions about how to contact HMSA.

Contents:

This section of the Summary Plan Description (or "SPD") summarizes the major features of the medical benefits program offered through the Edward D. Jones & Co. Employee Health & Welfare Program (the "Plan"). For more information about the medical benefits, please consult the "Claim, Appeal, and Legal Information" section.

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

Annual Deductible. The deductible is the amount of covered medical expenses you pay each calendar year before benefits begin. Any combination of family members can make up the family deductible. Once the family deductible has been satisfied, no other family members will have to meet a deductible in that year. The actual date of service is used when considering the deductible accumulation. For example, if a hospital stay begins on December 29th of one year and the patient is discharged January 2nd of the following year, the charges incurred from December 29th – 31st will be applied to the current year's deductible. The charges incurred January 1st – 2nd will be applied to the following year's deductible.

Anthem. Anthem Blue Cross and Blue Shield. Anthem is the sole designated claims administrator for all claims and appeals under the Medical Plan, including behavioral health. Pharmacy is carved out to Express Scripts. Effective 1/1/21 Anthem will administer all behavioral health benefits.

Coinsurance. The percentage of covered charges that you and the Medical Plan (defined below) share for the cost of your medical care after the deductible has been met, up to the out-of-pocket maximum (defined below). For example, if the Plan pays 85% of covered expenses, you pay the remaining 15% until you reach your Out-of-Pocket Maximum.

Coordination of Benefits (COB). When family members are covered for care under more than one group plan, benefits from this Medical Plan will be coordinated so that total benefits will not be more than 100% of the allowable covered expense. Discussed in further detail in the *Claim, Appeal and Legal Information* section of this SPD.

Covered Services. The Medical Plan pays for Covered Services and supplies received from either Network or Out-of-Network providers. This SPD identifies which services and supplies are considered Covered Services.

Experimental or Investigational Services. Medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time Edward Jones makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational);
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- therapeutic interventions not endorsed or widely accepted by the general medical community as the standard of care or best practice/intervention to treat the condition for which the intervention is intended.

As an exception to this general rule, if you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, Edward Jones may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, Edward Jones (or Anthem) must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Medical Plan. The medical coverage options offered through the Edward D. Jones & Co. Employee Health & Welfare Program. The Medical Plan offers two different coverage choices: the Premium Medical Plan and the Platinum Medical Plan, both of which use the Anthem network of providers. Each option has an annual deductible that applies to all of your care and treatment, including prescriptions, office visits, lab and x-rays, hospital care and outpatient treatment. After you satisfy the annual deductible, then the Medical Plan starts to pay your eligible expenses. When used in this section of the SPD, the term "Medical Plan" does not include the HMSA coverage option offered in Hawaii.

Maintenance Through Mail Prescriptions. Mail order prescription services are administered by Express Scripts. If you take prescription maintenance medications (those you take regularly or indefinitely, such as birth control, high blood pressure medication or high cholesterol medication), you may pay more by filling them at retail pharmacies. By moving your maintenance medications to mail you will likely save money.

If you are filling a maintenance prescription and after the third fill at a retail pharmacy you do not transfer to Express Scripts' mail service, the following will happen:

- Only 20% of the cost you pay will be applied towards your deductible or out of pocket maximum.
- After meeting your deductible, the Medical Plan will pay only 80% of the cost of a generic or brand drug instead of 100%. The portion you pay is subject to a $15 minimum charge.
- In all cases, the amount you pay toward your covered medical expenses in a calendar year (including deductible, coinsurance, and other amounts, and excluding premiums, pre-certification penalties, amounts incurred out of network and amounts incurred for non-covered benefits) cannot exceed the federal out of pocket maximum limits that apply to High Deductible Health Plans.

You should get all your short-term drugs, such as antibiotics, at a participating retail pharmacy.

Medical Channel Management for Prescriptions. Certain specialty drugs will be covered by the medical plan only if you obtain the drug from Express Scripts specialty pharmacy. When the physician's office contacts the medical plan for approval they will be told the medication should be filled through Express Scripts' specialty pharmacy, Accredo. Patient assistance may not apply to deductible and out of pocket maximums. If you obtain the drug from any other source (such as from your physician or an outpatient clinic), the drug will not be covered.

Network. Care that is received from a medical provider who contracts with Anthem is considered network care. You can choose from a list of Anthem's participating (Network) providers, including physicians, hospitals, and other health care facilities that agree to provide appropriate medical care services to medical plan participants for negotiated rates. You pay less for services when you use these Network providers because their charges are based on the negotiated rates. You can see any provider you choose, but you receive a higher level of coverage (and pay much less out of pocket) if you choose a Network provider. For a list of Anthem's network providers, including behavioral health providers go to www.edwardjonesbenefits.com. On the site select the Resources tab, then click Benefit Vendors. Upon request, you may obtain a paper copy of the provider lists by calling the appropriate benefit vendor above.

Network Transplant Provider. A provider that has been designated as a "center of excellence" by Anthem and/or a provider selected to participate as a Network Transplant Provider. These providers have entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A provider may be a Network Transplant Provider for some of the covered transplant procedures, or all covered transplant procedures.

Out-of-Network. Medical care services received under a medical plan that are *not* provided by (or coordinated through) a contracted physician or facility. Out-of-network services receive a much lower level of benefits, which means your out-of-pocket cost for medical services will be significantly higher. Out of network claims only pay 110% of Medicare Reimbursement.

Out-of-Pocket Maximum. Generally, the most that you pay toward your covered medical expenses in a calendar year that are not reimbursed by the Plan. This protects you from severe financial loss in the event of a serious illness or injury. This limit does not include:

- Deductibles
- expenses for any non-notification penalties
- non-eligible expenses, or
- expenses that are in excess of reasonable and customary charges.

When you or your eligible dependents have eligible expenses that meet the annual out-of-pocket maximum, all further eligible expenses will be paid 100% by the Medical Plan for the rest of that calendar year, except for copayments, non-covered charges, and any penalties that apply.

Prescription(s). Enrollment in the Medical Plan includes prescription drug coverage. All prescription benefits are administered by Express Scripts.

Prior Authorization for Prescriptions. A clinical review program that automatically applies a set of rules for certain prescription drugs to determine if the medication, dose and quantity are appropriate for a patient's condition. This program may require a health care provider to obtain approval from Express Scripts before a prescription may be filled.

Reasonable and Customary Charges. These are fees that the physicians or other providers charge patients for services. The fees are within the range charged by other physicians and providers who have similar training and experience in a similar geographic area. When you receive services from Out-of-Network providers, you may pay any fee that the provider charges that is over the reasonable and customary amount (sometimes called usual and customary charges), in addition to the higher coinsurance required for Out-of-Network care. In all cases, the reasonable and customary charge shall be determined by Anthem.

Step Therapy for Prescriptions. The practice of beginning a prescription drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

Wellness Program. The program within the Medical Plan which is reasonably designed to promote health or prevent disease.

Medical Benefits Summary

The Medical Plan offers two coverage options: the Premium Medical Plan and Platinum Medical Plan. These options are offered to all eligible associates. Both of the coverage options use the Anthem network of medical providers.

The Medical Plan is structured to provide the highest level of coverage with the lowest out-of-pocket costs to you when you use Anthem's network providers.

Medical Plan Summary. Both the Premium Medical Plan and the Platinum Medical Plan are considered "high-deductible health plans." This means that participants are eligible to contribute to a tax-deductible HSA. The plan covers in-network preventive care at 100% before the deductible is met. Each coverage option has an annual "combined" deductible (meaning that all of your covered medical, prescription and mental health treatment claims apply to the deductible). You pay the total cost of your medical treatment until you meet the deductible. Once the deductible is met, the plan starts to pay for eligible in-network expenses.

Prescription Coverage. Enrollment in the Medical Plan includes prescription coverage. All prescription benefits are administered by Express Scripts.

Behavioral Health (Mental Health & Substance Abuse Coverage). Enrollment in the Medical Plan includes coverage for behavioral health benefits, also referred to as mental health and substance abuse treatment. Effective 1/1/21, Anthem will administer all behavioral health benefits.

Note: Hawaii associates' medical benefits are provided by the Hawaii Medical Service Association (HMSA) medical plans. Information about the HMSA medical plans is available to you in a separate booklet. Please contact HMSA Member Services at (808) 948-6376 for more information. Information about filing a claim under the HMSA program can be found in the "Claim, Appeal, and Legal Information" of this SPD.

Patient Protection and Affordable Care Act ("PPACA"), Patient Protection Notices

Anthem generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in Anthem's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Anthem's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at the number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Medical Plan provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other covered health service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify Anthem. For information on notification or prior authorization, contact Anthem.

Premium Medical and Mental Health Plan Highlights

Feature	In Network	Out of Network[1]
Annual Deductible for Medical, Prescription[2], and Mental Health Expenses	$3,850 per person Maximum $7,750 per family	
Annual Out-of-Pocket Maximum (in addition to annual deductible)	$0 (No additional cost to patient after deductible is satisfied)	$2,000 per person Maximum $4,000 per family
Emergency Room[6,7]	100%, after deductible[7]	100%, after deductible
Urgent Care Centers	100%, after deductible	60%, after deductible
Virtual Doctor Visit ***Administered by LiveHealth Online***	100% after deductible LiveHealth Online operates its own Network of qualified providers Download mobile app or sign up online	60% after deductible LiveHealth Online operates its own Network of qualified providers. Download mobile app or sign up online

Medical, Prescription and Behavioral Health Benefits - 2023

Feature	In Network	Out of Network[1]
Physician's office visit (diagnosis or treatment of health condition)	100%, after deductible	60%, after deductible
Preventive Care for Adults (including routine physical and gynecological exam, mammogram, FDA-approved contraceptive methods for women, breast pumps, colonoscopy, immunizations, flu vaccines, a routine well vision exam, and prostate screenings). *For a detailed listing of all covered preventive services, see the Preventive Health Benefits section below.*	100%, no deductible	60% after deductible
Preventive Care for Children (includes immunizations)	100%, no deductible	60% after deductible
Lab & X-ray for diagnoses & treatment	100%, no deductible	60%, no deductible
Inpatient Hospital Medical Care[3]	100%, after deductible	60%, after deductible
Outpatient Surgery	100%, after deductible	60%, after deductible
Prenatal and Maternity Care	100%, after deductible	60%, after deductible
Hospital Care for Newborns[4] (Nursery care for well newborn is covered under mother's In-hospital deductible. Expenses incurred by a sick newborn are applied towards the newborn's own deductible.)	100%, after deductible	60%, after deductible
Skilled Nursing Facility[3, 5]	100%, after deductible (up to 120 days of inpatient care a year)	60%, after deductible (up to 120 days of inpatient care a year)
Home Health Care[3, 5]	100%, after deductible (up to 100 visits a year)	60%, after deductible (up to 100 visits a year)
Rehabilitation Therapy[5] **Physical** **Occupational** **Speech*** *Speech therapy provided for the treatment of Autism Spectrum Disorder is not subject to the 20 visit treatment limit	100%, after deductible (limited to 20 visits a year per type of therapy)	60%, after deductible (limited to 20 visits a year per type of therapy)
Manipulative Therapy[5]	100%, after deductible (up to 35 visits a year)	60%, after deductible (up to 35 visits a year)
Behavioral Health: Outpatient and Inpatient Mental Health, Drug Abuse and Alcohol Treatment	100%, after deductible	60% after deductible
Tobacco Cessation - *Administered by Virgin Pulse*		
Coaching Sessions	Telephonic coaching sessions are available to participants and the participant's spouse or domestic partner, if the spouse or domestic partner is enrolled in the medical plan. If the spouse or domestic partner is not enrolled, one of the participant's children, age 18 or older, may participate if covered under the medical plan. Eligible members can schedule via the web experience, app or by calling Member Services. Coaching topics cover the full spectrum of health and wellbeing needs, including weight management, stress, sleep, tobacco cessation, diabetes, and more. Coaches promote and facilitate the growth, healing and wellbeing of the whole person by eliciting intrinsic motivation, identifying opportunities and barriers related to desired changes, and empowering the individual in creating daily habits, structures and routines in pursuit of their vision for a thriving life	
Nicotine Replacement Treatment (NRT)	Tobacco cessation coaching participants can receive up to two months' supply of FDA-approved over-the-counter NRT via mail per wellness program year at no cost. Available forms include patches, lozenges and gum, in varying dosages	
Prescription Drugs[2] **- *Administered by Express Scripts***		
Generic Associate Choice Rx Program	If the patient's doctor does not believe a brand drug is required and patient requests a brand drug, the Medical Plan will only consider the cost of the generic drug. The patient pays any additional cost.	

Feature	In Network	Out of Network[1]
Maintenance Medications	If you don't get your maintenance medication from mail service, then after the 3rd fill at a retail pharmacy, only 20% of the cost will be applied towards your deductible. The remainder of the member responsibility is not applied to the deductible or out of pocket maximum. After you've met your deductible, the plan will pay only 80% of the cost of a generic or brand drug instead of 100%.	
Generic Prescription Drugs [2]	100% after deductible (assuming programs described above, prior authorization, and clinical review programs are adhered to)	
Brand Prescription Drugs [2]	100% after deductible (assuming programs described above, prior authorization, and clinical review programs are adhered to)	
Lifetime Maximum Benefit	Unlimited	

[1] Charges for Out-of-Network providers are subject to allowed limit, called reasonable and customary. Patient is responsible for amounts billed by provider that exceeds the allowed limit.
[2] Administered by Express Scripts. Prescription coverage levels shown assume patient complies with prior authorization, step therapy, and Maintenance Through Mail Programs. Certain preventative drugs that are classified as "preventative" are not subject to the deductible/copay requirements. Patient assistance may not apply to deductible and out of pocket maximums.
[3] Precertification is required to receive full benefits.
[4] Room and board and first doctor visit for a well newborn are covered under mother's deductible.
[5] In Network and Out–of-Network benefits are combined when determining dollar or time coverage limits.
[6] If you use emergency room or ambulance services for a non-emergency situation, no benefits will be paid.
[7] In an actual emergency, you will receive the In Network level of benefits regardless of the provider you use. If you use an Emergency Room for non-emergency care, the expense is not covered.

Platinum Medical Plan Highlights

Feature	In Network	Out of Network[1]
Annual Deductible for Medical, Prescription[2], and Mental Health Expenses	$4,850 per person Maximum $9,750 per family	
Annual Out-of-Pocket Maximum (in addition to annual deductible)	$0 (No additional cost to patient after deductible is satisfied)	$2,000 per person Maximum $4,000 per family
Emergency Room[6,7]	100%, after deductible[7]	100%, after deductible
Urgent Care Centers	100%, after deductible	60%, after deductible
Virtual Doctor Visit ***Administered by LiveHealth Online***	100% after deductible LiveHealth Online operates its own Network of qualified providers Download mobile app or sign up online	60% after deductible LiveHealth Online operates its own Network of qualified providers. Download mobile app or sign up online
Physician's office visit (diagnosis or treatment of health condition)	100%, after deductible	60%, after deductible
Preventive Care for Adults (including routine physical and gynecological exam, mammogram, FDA-approved contraceptive methods for women, breast pumps, colonoscopy, immunizations, flu vaccines, a routine well vision exam, and prostate screenings). *For a detailed listing of all covered preventive services, see Page 21*	100%, no deductible	60% after deductible
Preventive Care for Children (includes immunizations)	100%, no deductible	60% after deductible
Lab & X-ray for diagnoses & treatment	100% no deductible	60%, no deductible

Medical, Prescription and Behavioral Health Benefits - 2023

Feature	In Network	Out of Network[1]
Inpatient Hospital Medical Care[3]	100%, after deductible	60%, after deductible
Outpatient Surgery	100%, after deductible	60%, after deductible
Prenatal and Maternity Care	100%, after deductible	60%, after deductible
Hospital Care for Newborns[4] (Nursery care for well newborn is covered under mother's In-hospital deductible. Expenses incurred by a sick newborn are applied towards the newborn's own deductible.)	100%, after deductible	60%, after deductible
Skilled Nursing Facility[3, 5]	100%, after deductible (up to 120 days of inpatient care a year)	60%, after deductible (up to 120 days of inpatient care a year)
Home Health Care[3, 5]	100%, after deductible (up to 100 visits a year)	60%, after deductible (up to 100 visits a year)
Rehabilitation Therapy[5] **Physical Occupational Speech*** *Speech therapy provided for the treatment of Autism Spectrum Disorder is not subject to the 20 visit treatment limit	100%, after deductible (limited to 20 visits a year per type of therapy)	60%, after deductible (limited to 20 visits a year per type of therapy)
Manipulative Therapy[5]	100%, after deductible (up to 35 visits a year)	60%, after deductible (up to 35 visits a year)
Behavioral Health: Outpatient and Inpatient Mental Health, Drug Abuse and Alcohol Treatment	100%, after deductible .	60% after deductible .
Tobacco Cessation - *Administered by Virgin Pulse*		
Coaching Sessions	Telephonic coaching sessions are available to participants and the participant's spouse or domestic partner, if the spouse or domestic partner is enrolled in the medical plan. If the spouse or domestic partner is not enrolled, one of the participant's children, age 18 or older, may participate if covered under the medical plan. Eligible members can schedule via the web experience, app or by calling Member Services. Coaching topics cover the full spectrum of health and wellbeing needs, including weight management, stress, sleep, tobacco cessation, diabetes, and more. Coaches promote and facilitate the growth, healing and wellbeing of the whole person by eliciting intrinsic motivation, identifying opportunities and barriers related to desired changes, and empowering the individual in creating daily habits, structures and routines in pursuit of their vision for a thriving life	
Nicotine Replacement Treatment (NRT)	Tobacco cessation coaching participants can receive up to two months' supply of FDA-approved over-the-counter NRT via mail per wellness program year at no cost. Available forms include patches, lozenges and gum, in varying dosages	
Prescription Drugs[2] **- *Administered by Express Scripts***		
Generic Associate Choice Rx Program	If the patient's doctor does not believe a brand drug is required and patient requests a brand drug, the Medical Plan will only consider the cost of the generic drug. The patient pays any additional cost.	
Maintenance Medications	If you don't get your maintenance medication from mail service, then after the 3rd fill at a retail pharmacy, only 20% of the cost will be applied towards your deductible. The remainder of the member responsibility is not applied to the deductible or out of pocket maximum. After you've met your deductible, the plan will pay only 80% of the cost of a generic or brand drug instead of 100%.	
Generic Prescription Drugs[2]	100% after deductible (assuming programs described above, prior authorization, and clinical review programs are adhered to)	
Brand Prescription Drugs[2]	100% after deductible (assuming programs described above, prior authorization, and clinical review programs are adhered to)	
Lifetime Maximum Benefit	Unlimited	

[1] Charges for Out-of-Network providers are subject to allowed limit, called reasonable and customary. Patient is responsible for amounts billed by provider that exceeds the allowed limit.

[2] Administered by Express Scripts. Prescription coverage levels shown assume patient complies with prior authorization, step therapy, and Maintenance Through Mail Programs. Certain preventative drugs that are classified as "preventative" are not subject to the deductible/copay requirements. Patient assistance may not apply to deductible and out of pocket maximums.

[3] Precertification is required to receive full benefits.

[4] Room and board and first doctor visit for a well newborn are covered under mother's deductible.

[5] In Network and Out–of-Network benefits are combined when determining dollar or time coverage limits.

[6] If you use emergency room or ambulance services for a non-emergency situation, no benefits will be paid.

[7] In an actual emergency, you will receive the In Network level of benefits regardless of the provider you use. If you use an Emergency Room for non-emergency care, the expense is not covered.

Wellness Program

About the Wellness Program
If you are enrolled in the Medical Plan (with the exception of HMSA in Hawaii), you will have the opportunity to earn discounts on your Medical Plan premiums by participating in the Edward Jones Wellness Program. Edward Jones has partnered with Virgin Pulse to administer your Wellness Program rewards. In addition, Virgin Pulse will offer other fitness and health-related activities designed to support a healthy lifestyle.

The Wellness Program offers the following opportunities to earn discounts off your 2023 Medical Plan premiums:

There are a variety of options you can choose from to earn the 2023 medical premium discounts:

- **My Pulse Health Assessment:** $100 toward 2023 discount
  Associates and spouse/domestic partner, if currently enrolled in the Edward Jones medical plan, can earn up to a maximum of $800 each in 2023 medical premiums discounts. Note: Premium discounts are not available for Hawaii associates and their spouses/domestic partners.

- **Biometric Screening Measures:** Meet at least 3 out of 4 measures to receive the maximum $400 towards your discount. If you meet less than 3 measures, you will receive $100 for each measure you meet. For example, if you meet 1 out of 4 measures, you will receive $100; if you meet 2 out of 4 measures, you will receive $200.

- **Lifestyle Activities:** choose from and complete a variety of activities (ex. Submit gym membership form, track steps, track calories, complete a firm sponsored challenge, etc.) to earn up to a maximum of $300 toward your 2023 discount. A full list of activities and 2023 medical premium discount values can be found on the Virgin Pulse platform>Rewards>My Rewards

Medically enrolled associates hired on or after Jan. 1, 2023, will need to complete the Virgin Pulse New Member Registration Checklist no later than 60 days after their medical coverage is active to earn 2023 discounts. To create your Virgin Pulse account go to: join.virginpulse.com/EdwardJones.

Reasonable Alternatives are Available for Discounts
Rewards are available to all associates enrolled in the Edward Jones Medical Plan. If you think you and/or your spouse/domestic partner might be unable to meet the standard for a reward, you will qualify for an opportunity to earn the same reward by different means. You may contact Virgin Pulse at 1-833-880-4209, and they will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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Using the Medical Plans

Managing Your Health Care

The Medical Plan pays for Covered Services and supplies received from either Network or Out-of-Network providers. To receive the highest level of benefits under the Medical Plan, referred to as the Network level, care must be provided by a network provider. If care is not obtained from a network provider, benefits will be processed at a lower benefit level, referred to as the Out-of-Network level.

When seeking treatment at an in-Network facility, be sure to confirm that all physicians involved with your care are also in-Network to avoid any unexpected reduction in benefits.

Prescription benefits are administered by Express Scripts. Virgin Pulse administers the wellness program.

Medical Review Process
Some medical services require medical review by Anthem prior to the services being rendered. The medical review process is dependent upon what type of medical care you need and what type of provider you use. There are two types of medical review:

- Pre-determination
- Notification to Anthem

Pre-Determination
When you or a family member needs surgery or you're wondering if the Medical Plan covers a procedure, you and/or your health care provider should contact Anthem to obtain pre-determination (This SPD uses the terms "pre-determination", "pre-authorization", and "prior authorization" interchangeably). During this process, Anthem's medical professionals will review the type of treatment proposed and will tell you whether it would be covered under the Medical Plan. Failure to obtain a pre-determination could result in reduced and/or no benefit coverage of the services.

Out-of-Network Notification Requirements
Overview
If you receive medical care or services not provided by a Network provider, you must notify Anthem for any services listed below under *Mandatory Notification Requirements*. Anthem determines whether certain services and supplies are covered under the Medical Plan. No benefits are payable unless your medical plan administrator determines they are covered under the Medical Plan.

The ultimate decisions on medical care must be made by you or your physician. Anthem only determines if the medical service or supplies are covered under the Medical Plan according to the Medical Plan benefits, limitations and exclusions.

Approval by Anthem does not guarantee that benefits are payable under this Medical Plan. Benefit payments are based on services and supplies actually performed or given; your eligibility under this Medical Plan on the date the services and supplies are performed or given; and copayments, deductibles, coinsurance, maximum limits and all other terms and conditions of the Medical Plan.

Out-of-Network Mandatory Notification Requirements
Anthem must be notified for any of the services shown below. Anthem can be notified by calling the toll-free number shown on your medical ID card. Please call Anthem *prior* to receiving any of the following services **when care is not provided** by or coordinated through a network provider:

- inpatient admission to a hospital, skilled nursing facility or hospice,
- home health care, including private duty nursing,
- durable medical equipment (such as wheelchairs, hospital beds, CPAPs, catheters) or prosthetic devices costing $1,000 or more,
- reconstructive surgical procedures,
- maternity admissions exceeding the 48/96-hour guidelines,
- bariatric surgery,
- congenital heart disease services,

- organ or tissue transplant services,
- dental services needed as a result of an accident, or
- lab, x-ray and major diagnostics - CT, PET scans, MRI, MRA and Nuclear Medicine including diagnostic catheterization.

In-Network Services That Require Pre-Notification to Anthem

- **For Inpatient Confinements**
  - Prior to the scheduled admission (when reasonably practical)
- **For Pregnancy**
  - *Prenatal Programs:* During the first 12 weeks of pregnancy.
  - *Inpatient Confinement for Delivery of a Child:* Only if the inpatient care for the mother or child is expected to continue beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. Notify Anthem prior to the end of these 48/96-hour periods.
  - *Non-emergency Inpatient Confinement without Delivery of a Child:* Prior to the scheduled admission.
- **For Outpatient Services or Supplies which Require Medical Review**
  - Ten working days, if medically possible, prior to the service being given or supply purchased.
  - Services include radiology and cardiology imaging, such as CT scans, MRIs, PET scans and echocardiograms
- **For Organ/Tissue Transplants**
  - At least seven working days prior to any evaluation, donor search, organ procurement/tissue harvest or transplant and as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center)
- **For Bariatric Surgery**
  - As soon as surgery is recommended or being planned. *See Additional Covered Services and Supplies* section for more information.

A medical review is completed after Anthem is notified. You, your physician and the facility will be sent a letter confirming the results of the review.

Benefits Reduced if Anthem is Not Called

When care is provided by a Network provider, penalties do not apply. However, if you choose to receive care provided by an Out-of-Network provider and you (or your representative or physician) fails to call Anthem as required, benefits will be reduced. This reduction is called a Non-Notification Reduction. This reduction applies to each confinement, surgical procedure, medical supply or any treatment requiring notification to Anthem. The Non-Notification Reduction means the Medical Plan will pay only 40% of the allowed expense.

Appeals

If you do not agree with Anthem's review decision or Non-Notification Reduction as described above, you should follow the appeals procedure indicated in the Claim, Appeals and Legal Information section of this SPD.

Covered Services

The Medical Plan covers the following hospital and medical services and supplies for the treatment of an injury or disease. This section provides a detailed description of Covered Services. To make it easier for you to find, Covered Services have been listed in alphabetical order. Also, see *Additional Covered Services* at the end of this section for more information on eligible expenses.

Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD)

All ABA services will be coordinated through Anthem for those with a documented diagnosis of ASD. All claims for ABA and ASD will be reviewed for medical necessity under the terms of Anthem's applicable Medical Policies and Clinical Guidelines. Covered services may include the following: designated case contact for family/treatment providers to coordinate services as needed; referral to a qualified behavioral health clinician to confirm diagnosis; review of evaluation/testing results to determine most appropriate clinical services based upon client's clinical presentation; coordination with family and Autism treatment providers to ensure services are available to meet client's clinical needs; and bi-annual review of treatment plan and progress to ensure services continue to meet medical necessity criteria and are appropriate for the individual's clinical presentation. ABA providers or members must contact Anthem's Autism

Spectrum Disorders (ASD) Program at 1-844-269-0538 prior to engaging in ABA services to ensure services are covered and determine if pre-certification is required and/or case management assistance. The ASD Program provides clinical review of ABA assessment and treatment requests to ensure that appropriate and medically necessary care is being delivered. The program also offers autism-focused case management services to support members with coordination of care, resource referrals and educational information. ASD Program services are provided at no additional cost to members.

Behavioral Health - Mental Health and Alcohol and Drug Abuse
Anthem has contracted with many providers nationwide who specialize in the effective treatment of behavioral health conditions.

Network level benefits will be paid when you access care from a contracted Anthem provider, follow the rules for pre-authorization or emergency care, and follow the treatment recommendations. Treatment that is sought outside of the Anthem network is subject to the same out of pocket and deductible impacts as out of network medical coverage.

Behavioral Health - Non-Emergency Care
To receive the highest level of coverage under the Medical Plan, you or your covered dependent should contact Anthem before you seek non-emergency care. All inpatient treatment must be authorized by Anthem within the first 24 hours of the admission.

Behavioral Health - Emergency Behavioral Health Care
If you or your covered dependent has a life-threatening behavioral health emergency, seek care immediately at the nearest hospital. You or your family member must contact Anthem within the first 24 hours of the admission.

Behavioral Health - Mental Health & Substance Abuse Treatment
Mental health treatment is treatment for any condition:

- which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause; and
- when the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including room and board, given for a condition identified in the DSM are considered mental health treatment, unless there are multiple diagnoses. In the case of multiple diagnoses, only treatment for the condition identified in the DSM is considered mental health treatment.

Substance abuse treatment may be received on an inpatient basis in a hospital or an alternative facility, or on an outpatient basis in a provider's office or at an alternative facility. Detoxification services given prior to, and independent of a course of psychotherapy or substance abuse treatment are not considered behavioral claims but rather considered a medical claim and paid thru Anthem if approved. Non-abstinence based substance abuse treatment (such as methadone or suboxone) and nutritionally based substance abuse treatment is not covered except when medically necessary. Medication assisted therapies (e.g. Suboxone) are administered by the Prescription Benefit Plan.

Emergency Treatment
Treatment for an emergency situation is covered under the Medical Plan after a sudden and unexpected change in a person's physical or mental condition. The treatment is an emergency if failure to get immediate medical care could reasonably result in:

- placing the person's health in serious jeopardy,
- loss of life or limb,
- serious impairment to bodily function, or
- serious dysfunction of a body part or organ.

Covered treatment in emergency situations also includes immediate treatment for a mental disorder when lack of treatment could reasonably result in the patient harming himself, herself or others.

Covered Services include those provided by:

- hospital emergency room,
- urgent care facility, or

- ambulance, ground, and local transport, if medically necessary, to the nearest local facility for required treatment. Note: air ambulance transfer service is typically only provided by an out of network medical provider which leaves the member subject to the reasonable and customary payment amounts.

If you experience an emergency, or if you need to see a physician while you are traveling, you need to take the following steps:

In the Event of an Emergency		Treatment While Traveling	
If you have an emergency, go immediately to the nearest emergency room. Then:	Contact your doctor within 24 hours of the emergency treatment or on the first working day following a weekend or holiday. If your doctor is notified and you follow his or her guidance, expenses will be considered at the Network level of benefits.	If your condition is *not* an emergency:	Contact Your health Medical Plan before seeking treatment. Your Medical Plan will put you in touch with the nearest contracted provider or recommend an alternative medical plan of action.

Use of Emergency Rooms and Urgent Care Centers
In an actual emergency, you will receive the Network level of benefits regardless of the provider you use for emergency care. However, you must contact your Network doctor for any additional treatment that stems from the emergency after the emergency has ended. If you do not, those benefits will be payable at the Out-of-Network level. For more information about additional requirements, see the above *Medical Review Process* section.

If you use emergency services for a non-emergency situation, no benefits will be paid. People sometimes use emergency rooms to find a physician at night or because they don't know where else to turn. For example, in general, a cold, the flu or a sore throat is not considered an emergency. The Medical Plan does not pay benefits for any non-emergency use of the emergency room if it is determined that a less intensive (or more appropriate) treatment could have been given in a more appropriate setting.

Gender Affirming Care

Anthem's Inclusive Care Program provides trained health guides from an advocacy service which provide one-on-one gender affirmation guidance and surgery support, assistance with finding doctors and hospitals that specialize in gender affirming care, and assistance in locating HIV treatments and fertility care.

Anthem Health Guides may provide you with dedicated customer service support to help you navigate the health care system. Their services may help you to stay on top of preventative care, tests, and exams; to compare provider costs and services; to find in-network doctors and mental health providers; and to work with your providers for health care pre-authorizations. Travel benefits, which are more fully discussed below, may also be available if an-network provider is not available within 50 miles of your home.

The Plan provides coverage for gender affirming health benefits to associates and covered dependents who have a diagnosis of and meet Anthem's clinical requirements for gender dysphoria.

Subject to Anthem's medical policies, gender affirming care includes hormone replacement therapy, reconstructive chest, breast, and genital surgery, and other services, more fully described below, such as facial feminization surgery, voice modification, tracheal shave, and thyroid reduction surgery.

More specifically, the Plan covers benefits for the treatment of gender dysphoria as follows:
- Psychotherapy for gender identity disorders/dysphoria,
- Continuous hormone replacement with hormones of the desired gender injected by a medical provider or oral hormone prescriptions prescribed by a valid provider, and
- Genital surgery and surgery to change secondary sex characteristics, including thyroid chondroplasty, bilateral mastectomy and augmentation mammoplasty.

The treatment plan must meet certain requirements, including;

- For irreversible surgical interventions, the patient must be age 18 years or older,
- Prior to surgery, the patient must complete 12 months of successful continuous full-time, real life experience in the desired gender,
- Prior to surgery, the patient must complete 12 months of psychotherapy, and
- Prior to surgery, the patient must provide two letters from a qualified health provider who has assessed the readiness of the patient for the treatment.

Certain patients will be required to complete 12 months of continuous hormone therapy prior to surgery. In consultation with the patient's physician, this will be determined on a case-by-case basis through the Prior Authorization process.

Augmentation mammoplasty is allowed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role.

Anthem and Express Scripts have specific medical policies and clinical guidelines regarding benefits for treatment of Gender Identity Disorder, including prior authorization requirements. Contact them at the telephone number on your ID card for information about these guidelines.

Remember that the usual deductibles and cost-sharing for your Medical Plan coverage option will apply to these benefits and services.

In addition to the other exclusions and limitations for Medical Plan benefits, the Plan will not pay for the following gender identity-related services and procedures:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics, or
- Treatment received outside of the United States

Home Health Care

For Network level coverage, you must use a contracted home health agency (if available in your area).

Home health care expenses are covered if:

- the charge is made by a home health care agency,
- the care is given under a home health care medical plan, or
- the care is given to a person in their home.

Eligible home health care expenses are charges for:

- temporary or part-time nursing care by or supervised by an R.N.,
- temporary or part-time care by a home health aide,
- physical therapy,
- occupational therapy, or
- speech therapy.

For members that are confined to the home or have limited absences from the home.

A maximum of 100 visits (Network/Out-of-Network combined) is covered in a calendar year. Each visit of up to four hours by a home health aide is considered one visit. Each visit by any other member of the home health team will count as one visit.

Defining Home Health Care Agency

A home health care agency is an agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with applicable licensing and other laws.
- It meets ALL of the following tests:
    - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.

- It has a full-time administrator.
- It maintains written records of services provided to the patient.
- Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by an available R.N. Its associates are bonded and it maintains malpractice insurance.

Hospice Care
Hospice care is care for terminally ill Medical Plan participants. It is designed to treat the unique physical and mental distress of terminal illness by addressing both the physical and emotional needs of the patient and the patient's family. For Network level coverage, services must be rendered by a contracted hospice agency (if available in your area).

Covered hospice care services include charges for the following:

- room and board in a hospice facility (including a hospice facility which is part of a hospital), not including:
  - any charges over the hospital's most common semiprivate room rate, or
  - any charges over the hospice facility's maximum room and board daily benefit.
- certain skilled nursing or home health aide services, counseling, respite care or other therapy. These Covered Services include:
  - skilled nursing or home health aide services provided by an R.N. or an L.P.N., when necessary,
  - counseling services for the terminally ill participant and a member of his or her family provided by a psychiatrist, psychologist or a state-licensed social services organization,
    - The terminally ill person's physician must determine that the terminal illness is the direct cause of the mental state of the person requiring counseling. Services to the covered person's family may extend for up to six months after the death of the covered person.
  - respite care services provided by a homemaker service for up to a maximum of seven days. Services must be approved by the hospice program and your Medical Plan
  - physical, respiratory or speech therapy when approved by the physician and the hospice program,
  - licensed nutritionist or dietician when medically necessary to the hospice program,
  - local ambulance service or special transport services between home and the hospice facility when approved by the hospice program, and
  - other services including doctor's services, medical supplies, medicines, drugs, and rental (or purchase, if rental would cost more) of durable medical equipment which are deemed medically necessary by the PCP or specialist and provided through the hospice program.

Hospital Services
If you use a Network hospital, the Medical Plan will pay the higher Network level of benefits.

If you use an Out-of-Network hospital, the Medical Plan will pay 60% of allowed charges (subject to the annual deductible), as long as Anthem pre-approves your stay. An allowed charge is the expense that would have been considered if you had used a Network hospital. The hospital is likely to bill you more than the allowed level, and you'd be responsible for the difference.

Covered inpatient hospital services include:

- room and board at a semiprivate room rate (or 90% of the hospital private room rate)
- other services and supplies as medically necessary, and
- emergency room care, if appropriate (for more information, see the above *Emergency Treatment* section).

Infertility / IVF
The Medical Plan will cover the infertility services as described in this section. The following services are covered up to a $15,000 lifetime benefit maximum for individuals who are infertile and who have failed to achieve a pregnancy using other generally acceptable methodologies of treating infertility. The services must be preauthorized by calling Anthem's Medical Management Program at least two weeks prior to the initiation of hormone treatment services. Failure to obtain preauthorization of services will result in a denial of benefits.

The following procedures are covered:

- Artificial Insemination Cycles (including intrauterine insemination-iui) stimulated with ovulatory stimulants (e.g., Clomid) or aromatase inhibitors (e.g., Letrozole) or completed without stimulation medications.
- Advanced reproductive technologies:

  - In-Vitro Fertilization (IVF)
  - Frozen Embryo Transfer (FET)
  - Zygote Intrafallopian Transfer (ZIFT)
  - Gamete Intrafallopian Transfer (GIFT)
  - Intracytoplasmic Sperm Injection (ICSI)
- Medically necessary and appropriate diagnostic workup and radiology services.
- Pathology and laboratory services, including:
  - Hormonal assays
  - Swimup semen analysis, as appropriate
  - Ultrasound exams
  - Fertilization and embryo culture
  - Ova retrieval
  - Embryo, gamete-zygote transfer
  - Cryro preservation for the following:
    - blastocysts(s) and embryo(s) from covered IVF cycles. Covered blastocyst and embryo storage is limited to one year for each blastocyst and embryo; and
    - oocytes as directed by medical policy.
- Medications necessary to the provision above, including parenteral injection and oral ovulation induction drugs.

All frozen embryos stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

The following services are not covered:

- Related donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications).
- No coverage for IUI Cycle stimulated with gonadotropins or menotropins.
- Fallopian tube ligations and vasectomy reversals.
- Surrogacy and any fees associated with it (maternity services are covered for Members acting as a surrogate mother) Medical and surgical procedures that are experimental or investigational, unless such denial is overturned by an External Appeal Agent.
- Services requested which are not medically appropriate.
- Services not specifically listed as covered in this benefit.
- Services rendered by non-participating providers, unless authorized by the Medical Management Program.

OB/GYN-Related Services
Benefits are payable at the Network level for age recommended females for well care services such as routine well-woman exams, including breast exams and/or routine mammogram screening for breast cancer, pelvic exams, and pap smears. For more information, see the below *Preventive Health Care Benefits* or the *Pregnancy and Delivery* sections.

Oral Surgery/Dental Services
Your medical benefits cover certain oral surgery/dental services including:
- oral surgery as part of the treatment for an underlying medical condition,
- as needed because of accidental injury, or
- as needed because of an injury caused by domestic violence , including:
  - oral surgery
  - full or partial dentures
  - fixed bridgework
  - repair to natural teeth, and
  - crowns.

Organ/Tissue Transplants

You and your dependents are covered for qualified procedures performed at a Network transplant facility designated by Anthem. The Medical Plan pays 100% of eligible expenses at a designated transplant facility. If a transplant facility designated by Anthem is not used, no benefits will be payable.

Donor charges for organ/tissue transplants are also covered if the donor recipient is covered under this Medical Plan. Anthem must be notified at least seven working days before the transplant evaluation, donor search, organ procurement/tissue harvest or transplant procedure.

Examples of transplant procedures covered under the Medical Plan include:
- heart, except artificial heart,
- lung or double lung,
- human heart/lung,
- liver,
- kidney,
- pancreas,
- kidney/pancreas,
- kidney/liver, and
- bone marrow/stem cell.

Transplant covered medical care and treatment services include:
- pre-transplant evaluation,
- organ acquisition and procurement,
- hospital and physician fees,
- transplant procedures,
- follow-up care for up to one year,
- travel costs as described in below, and
- search for bone marrow/stem cell from a donor who is not biologically related to the patient. Benefits are available to the donor and the recipient when the recipient is covered under this Medical Plan. The transplant must meet the definition of a covered health service and cannot be Experimental or Investigational Service or unproven.

Examples of transplants for which benefits are available include but are not limited to:
- heart,
- heart/lung,
- lung,
- kidney,
- kidney/pancreas,
- liver,
- liver/kidney,
- liver/intestinal,
- pancreas,
- intestinal, and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a *covered health service*.

Physician Services
Physician services covered under the Medical Plan include:
- hospital, office, home visits and emergency room services;
- services for surgical procedures;
- charges for second surgical opinions;
- reconstructive surgery to improve the function of a body part because of birth defect, sickness or accidental injury, an injury caused by domestic violence, because of a mastectomy, or to remove scar tissue on the neck, face or head because of a sickness, accidental injury, an injury due to an act of domestic violence; or
- assistant surgeon services (covered up to 1/5 the amount of covered expenses for the surgeon's charge for the surgery).

Pregnancy and Delivery Benefits

Benefits are payable for Covered Services in the same manner as other benefits under the Medical Plan. Benefits are payable for Covered Services and supplies for a minimum of 48 hours of inpatient care for the mother and newborn following a normal vaginal delivery or for up to 96 hours following a cesarean section. Notification is required for longer lengths of stay.

Additional Covered Services and supplies specific to pregnancy include:

- Screenings during pregnancy, including but not limited to gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV.
- birthing center services including room and board, other services and supplies;
- services of a licensed or certified nurse-midwife;
- routine newborn care during a newborn's initial hospital confinement, whether or not the child has been enrolled in the Medical Plan, including:
    - hospital services for nursery care
    - other services and supplies given by the hospital, including screenings for hearing impairment, sickle cell disease, phenylketonuria, congenital hypothyroidism, and prophylactic ocular topical medication to prevent gonococcal ophthalmia neonatorum.
    - services of a surgeon for circumcision, and
    - physician services
- therapeutic abortions – an abortion induced for the sake of the mother's physical or mental health or to prevent the birth of a congenitally compromised child or a child conceived as a result of a nonconsensual sexual intercourse (elective abortions are not covered).

Inpatient nursery charges for a well newborn are considered under the mother's annual deductible. Charges for treatment of a sick newborn are subject to the newborn's own deductible if the child is enrolled in the Medical Plan.

Hospital Stays for Childbirth

Federal law sets the following minimum coverage for hospital stays for childbirth:

- 48 hours following delivery for vaginal birth, or
- 96 hours following delivery for caesarian section.

Approval from Anthem is not required for hospital stays that are less than or do not exceed these minimum time limits. The minimum length of stay applies to both the mother and newborn.

The mother, in consultation with her doctor, the hospital or other provider, may agree to an earlier discharge. If the discharge occurs earlier than the minimum requirements, the Medical Plan only pays benefits on the actual length of stay. However, hospital stays that are expected to exceed the minimum length of stay must be approved by Anthem to receive maximum benefits for that maternity care.

Prescription Drugs

Express Scripts administers the prescription drug benefit on behalf of the Edward D. Jones & Co. Employee Health & Welfare Program. Express Scripts has negotiated certain rebates with participating drug manufacturers. Express Scripts has agreed that the Health & Welfare Program will receive the benefit of these rebates.

Depending on the drug prescribed by your doctor, you or your pharmacist may be directed to obtain prior authorization from Express Scripts before the prescription can be filled.

Maintenance medications are those you take regularly. The Medical Plan includes financial incentives to encourage you to obtain the drug via Express Script's mail service rather than at the retail pharmacy. In addition, certain specialty medications will be covered only if they are obtained via Express Script's specialty mail pharmacy, Accredo. If these situations apply to you, Express Scripts will notify you. Due to the high cost of specialty medications, Express Scripts via Accredo, may help patients find manufacturer supported financial assistance programs when needed. The financial assistance you may receive will not count toward your deductible.

The Medical Plan also encourages the use of lower-cost generic drugs. If you request a brand drug even though your doctor agrees that a lower-cost drug is suitable for your situation, the Medical Plan will only consider the lower cost drug, and you would be responsible for paying the additional expense.

The Medical Plan no longer covers certain compound prescriptions. The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription.

If a member received a drug co-pay assistance coupon or discount card, please note the amount of the coupon discount will not apply to the member's deductible and out of pocket maximums. Only the portion that the member truly pays will be attributed to the deductible and out of pocket maximums.

To the extent the Health & Welfare Program receives rebates based on Express Script's negotiated rebates, including the receipt of rebate payments in connection with prescription drugs purchased by Program participants, such amounts will be sent directly to the Program and shall be held for the exclusive purpose of providing benefits to Program participants and beneficiaries and defraying reasonable expenses associated with the Program.

Preventive Health Care Benefits
Medical Plan members are encouraged to take advantage of annual checkups, immunizations, mammograms and other types of screenings. Early detection and prevention of disease have been proven to have a beneficial effect on health outcomes. Preventive health care obtained through the Medical Plan is covered at 100% before annual deductible if services are provided by a Network physician.

Preventive versus Diagnostic Care
Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing symptoms or suspected illnesses.

For example, an adult makes an appointment for a routine preventive exam (there weren't any medical concerns or symptoms that prompted the appointment). The doctor suggests a glucose and cholesterol test which are considered preventive care, and the cost of the test and exam would be covered by the Medical Plan before deductible. On the other hand, if the patient made an appointment for an exam after experiencing some symptoms, the exam and any related tests ordered by the doctor would be considered diagnostic and the expense would be applied towards the annual deductible.

In general, the Medical Plan covers many of the preventive care screenings recommended by the U.S. Preventive Services Task Force (USPSTF), and other preventive care services may be covered as well.

Adult (ages 18 and older) preventive health care benefits include:

- Routine physical exam, which includes screening tests for blood pressure, cholesterol and lipid level, glucose levels, height, weight and BMI, fecal occult blood test, screening sigmoidoscopy, and diabetes (Type 2) screening for adults with high blood pressure.
- Tobacco cessation counseling, including medications indicated for tobacco cessation therapy, alcohol misuse screening and counseling, diet counseling for adults at higher risk for chronic disease, obesity screening and counseling, and Sexually Transmitted Infection (STI) prevention counseling.
- Dietary counseling for qualifying adults with obesity, hyperlipidemia, and other known risk factors for cardiovascular and diet-related chronic disease is also covered as preventive care. The counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- Colorectal Cancer Screening is considered preventive care and is recommended for adults ages 50-75 (available before age 50 if deemed necessary). Preventive services include the Fecal Immunochemical Test, Fecal DNA test or a colonoscopy. The procedure, as well as pre-service consultation, is covered at any frequency as recommended by your physician and is available before age 45 if family history deems necessary. Certain bowel prep medications necessary for the exam are also considered preventive. Preventive coverage also includes the removal of polyps during the colonoscopy procedure. If further testing or treatment is needed as a result of the colonoscopy, the services will be considered diagnostic and the expense would be applied towards the annual deductible.
- Routine eye exam which, includes refractive testing, at a Network ophthalmologist or optometrist, or as part of an annual routine exam in a provider's office. (Please note, charges for purchase or fitting of eyeglasses or contact lenses are excluded, unless required as a direct result of and during 12-months following cataract surgery).
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These include Influenza (Flu Shot), Measles, Mumps, Rubella, Diphtheria, tetanus and pertussis (whooping cough); Hepatitis A and B; human papilloma virus (HPV); Influenza; meningococcal (meningitis); pneumococcal (pneumonia); varicella (chicken pox); non-routine

vaccines (anthrax, tuberculosis, cholera, Japanese encephalitis, rabies, typhoid, yellow fever). Zoster (shingles) vaccinations are covered for patients age 60 and older. Shingrix (shingles) vaccinations are covered for patients age 50 and older. COVID-19 for those ages approved by the CDC.

- Lung cancer screening beginning at age 55-80 if a heavy smoker or have quit in the past 15 years.
- Hepatitis C screening for adults at risk, and one time for everyone born between1945-1965.
- HIV screening and counselling for ages 15-65, and at increased risk.
- HIV medication prescribed to people who don't have HIV but are at high risk (PrEP), medication prescribed to prevent HIV after possible exposure (PEP), and medications that reduce the risk of transmitting HIV (ART).
- Statin drugs for cardiovascular disease for adults ages 40-75 at high risk.
- Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.

For males, preventive health care benefits also include the following, if age appropriate:

- One annual routine prostate-specific antigen (PSA) test per year beginning at age 40;
- Screening for abdominal aortic aneurysm (for men who have smoked tobacco and are age 65-75); and
- Aspirin use to prevent cardiovascular disease between the ages of 45-79.

For females, the following preventive health care benefits are covered, including well-woman exams:

- Pelvic exam and Pap test including screening for cervical cancer at any age, as recommended by your doctor, screening for HPV, chlamydia, syphilis, gonorrhea, and other sexually transmitted infections at any age, as recommended by your doctor.
- Human Papillomavirus (HPV) screening for women ages 30 to 65 every 5 years with the combination of Pap smear or hrHPV testing; or every 3 years with cervical cytology alone.
- Domestic violence screening and counseling.
- Aspirin use to prevent cardiovascular disease and for those pregnant persons at high risk for preeclampsia for ages less than 70.
- Breast Cancer Chemoprevention counseling for women at high risk.
- Genetic counseling and BRCA1 or BRCA2 testing for women with a family history of breast, tubal, peritoneal or ovarian cancer. In addition, for those who are determined to be at increased risk after genetic testing, prescriptions for Tamoxifen, Raloxifene and Soltamox cancer prevention drugs will be covered as preventive health benefits if the determined use is for primary prevention of breast cancer.
- Breast exam and routine mammogram screening as follows:
    - baseline mammogram from age 35 to 39; or
    - mammogram every 1 to 2 years for women over 40

  Three dimensional (3-D) mammograms are covered under the preventive mammogram benefit. Breast ultrasound (unilateral or bilateral) and MRI of the breast will be covered as preventive health benefits only when the patient has:
    - density of the breast tissue so that a routine mammogram is not useful in identifying tumors; and
    - no symptom prompts the test (the patient was attempting to obtain a routine screening for breast cancer).
- Bone density (osteoporosis) screening for qualifying women younger than 65 and all women 65 and older.
- FDA approved contraceptives (when prescribed with a valid prescription) and contraceptive services (including female sterilization) for women with reproductive capacity to prevent pregnancy.

For pregnant females, the following preventive health care benefits are covered:

- Screening in pregnant women for anemia, bacteriuria, hepatitis B virus, Rh incompatibility, gestational diabetes (24-28 weeks pregnant), pre-eclampsia, urinary tract or other infections.
- Hepatitis B screening at first prenatal visit.
- Gestational diabetes screening
- Folic acid supplements for women who may become pregnant.
- Breastfeeding support, equipment (see below for details) and counseling for pregnant and nursing women:

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

Benefits are only available if breast pumps are obtained from a durable medical equipment provider or physician. If more than one breast pump can meet your needs, benefits are available only for the most cost effective pump. Anthem will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition.

Child (under age 18) preventive health benefits include:

- Child preventive care services in connection with routine pediatric care, including flu vaccinations, blood pressure, lead screening for children at risk, thyroid disease, sickle cell anemia, standard metabolic screening panel for inherited enzyme deficiency diseases, PKU tests, and immunizations.
- Autism screening for children 18-24 months.
- Gonorrhea preventive medication for the eyes of all newborns.
- Immunizations including: Diphtheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate haemophilus influenzae type B, Hepatitis B, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for females age 9-18. COVID-19 for ages approved by the CDC.
    - The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.
- One routine eye exam per year, including refractive testing, at a Network ophthalmologist or optometrist.
- Alcohol and Drug use assessment for adolescents.
- Developmental screening for children under 3 years of age.
- Depression screening routinely beginning at age 12.
- Behavioral assessments for all ages 0-17 years of age.
- Obesity screening and counseling. Dietary counseling for child patients with obesity, hyperlipidemia, and other known risk factors for cardiovascular and diet-related chronic disease is also covered as preventive care. The counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians
- Generic fluoride chemoprevention supplements for children without fluoride in their water source.
- Generic fluoride varnish for all infants and children as soon as teeth are present.

Physicians sometimes order additional tests, such as Vitamin D testing, Urinalysis, Thyroid testing and Complete Blood Count (CBC testing). These tests are not considered preventive health care and would be applied towards your annual deductible.

The Medical Plan pays benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility such as a retail health clinic, or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Rehabilitation Therapy (Physical/Occupational/Speech)

This Medical Plan covers three different types of rehabilitation therapy: physical, occupational and speech. Both inpatient and outpatient services are covered.

Inpatient Rehabilitation Therapy
Covered inpatient services are limited to a combined total of 120 days of confinement in a hospital, skilled nursing facility and/or rehabilitation facility each calendar year. Covered inpatient services include:

- hospital, rehabilitation facility room, board, care and treatment during a confinement, and
- rehabilitation therapy if multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Outpatient Rehabilitation Therapy
Covered outpatient services include up to 20 days of hospital or comprehensive outpatient rehabilitation facility therapy services per calendar year. Each day of therapy reduces the number of visits under Covered Services for outpatient physical therapy, outpatient occupational therapy or speech therapy. Up to 20 visits for each type of therapy is covered. Medical appropriateness review required after 20 visits.

Following is a list of covered outpatient rehabilitation treatments and services:

- outpatient occupational therapy – you and your covered dependents are covered for occupational therapy that is:
  - ordered and monitored by a physician in accordance with a written treatment plan, and
  - approved by the attending physician;
- physical therapy – you and your covered dependents are covered for physical therapy that is:
  - ordered and monitored by a physician in accordance with a written treatment plan, and
  - approved by the attending physician;
- speech therapy – services from a licensed provider for patients age six and older are covered if they are needed to restore speech lost or impaired because of:
  - surgery, radiation therapy or other treatment which affects the vocal chords,
  - cerebral thrombosis (cerebral vascular accident),
  - brain damage due to accidental injury or organic brain lesion (aphasia),
  - accidental injury, or
  - an act of domestic violence.

Second Opinion Services
The Medical Plan offers a second opinion service through Consumer Medical. Through Consumer Medical, you'll work with a support team of qualified health care professionals who aren't connected to your doctor or Anthem. They can:

- Help you get a "virtual" second opinion
- Refer you to a doctor in your plan for a second opinion
- Provide information to help you make a decision about your care

Call the Virtual Second Opinion program and speak with a nurse at 1-888-361-3944 Monday – Friday, 8:30 a.m. to 11:00 p.m. Eastern Time.

Skilled Nursing Facility Services
You and your covered dependents are covered for up to 120 days of confinement each calendar year in a skilled nursing facility. Covered Services include:

- room and board at a semiprivate room rate, and
- other services and supplies as medically necessary.

Travel Benefits for Covered Services
The Medical Plan will cover reasonable travel and lodging expenses when an in-network provider is not available to provide any Covered Service within 50 miles of a participant's home. Generally, covered travel includes the reasonable transportation, lodging and meal expense for the Participant and one companion (two companions if the patient is a dependent child). Benefits are capped at a daily rate of $50 for one person or up to $100 for two people for lodging and meals. If the patient is a covered dependent child, lodging and meals may be reimbursed for two companions, up to the $100 daily rate. Mileage to and from the treatment location will be reimbursed at the same rate the firm pays associates for mileage incurred for business travel. The Plan Administrator retains discretionary authority to modify the terms of this provision. For purposes of this travel provision, an in-network telehealth provider may be considered an in-network provider.

Reimbursements for lodging are excludible from an associate's taxable income up to $50 per person per day. Edward Jones will report as taxable income of an associate any reimbursement for lodging or meals served inside the medical facility that exceeds $50 per person per day and any reimbursement for meals outside of a medical facility on the

applicable year's Form W-2. To ease any additional income tax burden caused by the inclusion in taxable income of these reimbursed amounts, however, Edward Jones will "gross up," or pay to the applicable tax authority on an associate's behalf an additional amount approximating the tax cost, if any, of these benefits. This gross up is also considered taxable income.

Virtual Doctor Visits
Anthem has contracted with authorized service providers who provide access to a network of board-certified doctors virtually. Members may visit a doctor from their home using a computer, tablet or smart phones which contain a camera. This service is provided through a network of board certified doctors who can provide certain medical services to you via a virtual doctor visit. Most visits take under 30 minutes, and in some cases, if needed, your doctor can write a prescription.*

*Some virtual doctor visit providers are not available in certain states, due to state regulation. This restriction applies to the location at the time the service is rendered. Prescription services may not be available in all states. See the chart at www.edwardjonesbenefits.com to identify which states restrict these services.

Additional Covered Services and Supplies

The following services and supplies are also covered and payable under this Medical Plan if medically necessary and pre-certified when appropriate:

- acupuncture treatment performed by a licensed provider,
- allergy testing and treatment,
- ambulatory surgical center services (services must be provided within 72 hours before or after a surgical procedure),
- anesthetics,
- bariatric (gastric bypass) surgery – covered only if approved by Anthem as medically appropriate and only if surgery is obtained from Anthem's designated Bariatric Blue Distinction Center of Excellence. In addition to the Plan's travel benefit guidelines provided above, the Medical Plan imposes a $500 lifetime cap of the travel reimbursement benefit for Participants undergoing bariatric surgery and travel reimbursement is only available if the bariatric center is more than 50 miles from the Participant's home.
- breast reconstruction, if you or your covered family members:
    - received benefits for a mastectomy, and/or
    - underwent elective breast reconstruction in connection with the mastectomy.

  As long as the breast reconstruction is performed in a manner determined by the patient in consultation with the attending physician, benefits include:
    - reconstruction of the breast on which the mastectomy was performed,
    - surgery and reconstruction of the other breast to produce a symmetrical appearance, or
    - prostheses, holding bra, and treatment of physical complications of all stages of mastectomy, including lymphedemas.
- breast reduction provided it is not for cosmetic reasons,
- cardiac rehabilitation,
- cataract surgery,
- Cervical and Thoracic Discography, used in the diagnosis of cervical and thoracic pain syndromes in individuals being considered for surgical intervention,
- chemotherapy,
- Christian Science treatment (including services from a licensed practitioner, a licensed nurse who does not live in your home or who is not a member of your immediate family, and room and board in a Christian Science sanatorium),
- manipulative therapy (medically necessary treatment covered for up to 35 visits each year; benefits can be denied or shortened if patient is not progressing in goal-directed manipulative treatment or goals have been met; benefits are not available for maintenance/preventive treatment),
- cochlear implants for adults and children (ages consistent with FDA indications) for the following diagnosis: Severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or post-lingual sensorineural deafness in an adult,
- contraceptive IUDs and diaphragms,
- eyeglasses or contact lenses (one pair of either, not both) within 12 months following cataract surgery only,
- dialysis (both hemodialysis and peritoneal dialysis),

- durable medical equipment that is for repeated use and is not a consumable or disposable item. Equipment must be for a medical purpose and appropriate for use in the home (for example, orthotic devices such as an arm brace, hospital-type beds, and monitoring devices). You should check with Anthem for coverage when considering a piece of durable medical equipment,
- foot care as necessary due to severe systemic disease,
- hearing aids –The Medical Plan will cover the cost of hearing aids, dispensing fee, molds and impressions, up to a $2,500 benefit allowance once every three years, provided there is medical necessity,
- insulin pumps and supplies,
- intravenous chemotherapy and infusion therapy,
- laboratory tests and x-rays for diagnosis or treatment,
- leadless pacemaker, an implantable transcatheter pacing system to monitor and regulate the heart rate and rate-responsive bradycardia,
- licensed or certified nurse-practitioner services,
- medical supplies, including surgical supplies and blood or blood derivatives (only if not donated or replaced),
- medical transportation by professional ambulance to and from the nearest medical facility qualified to give the required treatment, or transportation by a regularly-scheduled airline, railroad or air ambulance *to (not from)* the nearest medical facility qualified to give the required treatment (services must be given within the United States, Puerto Rico or Canada),
- obesity treatment, including physician services, lab fees, and prescription drugs when approved by Anthem and determined, in accordance with Anthem's internal guidelines, to be medically necessary, and only when obtained from your health plan's designated facilities,
- multiple surgical procedures (covered expenses for a secondary procedure are limited to 50% of the covered expense had it been performed during a separate operative session and 25% for any subsequent procedure),
- nutritional counseling as described in the Preventive Care section. In addition, Nutritional Counseling is covered as treatment for eating disorders (after deductible) and for pregnant women who have been diagnosed with gestational diabetes,
- orthoptic training (eye muscle exercise) by a licensed optometrist or orthoptic technician, up to a lifetime maximum of 20 visits for you or your spouse and up to 30 visits for each covered dependent child,
- ostomy supplies obtained from sources other than Express Scripts,
- pneumatic compression devices for lymphedema, to address the home use of pneumatic compression devices for the treatment of lymphedema addresses the home use of pneumatic compression devices,
- prescription drugs to treat medical conditions, including but not limited to:
    - oral and injectable contraceptives,
    - vaginal estrogen,
    - prenatal vitamins,
    - diabetic supplies and prescriptions, including syringes and needles, insulin supplies (insulin pumps covered only through Anthem), blood monitors and kits, blood test strips, blood glucose calibration solutions, urine tests, Lancets, Lancet devices, and insulin. Swabs are not covered.
    - respiratory therapy supplies (aerochamber, spacers and nebulizers),
    - non-insulin syringes, and
    - Tamiflu and Relenza.

  The above is not meant to be an exhaustive list. In order for a prescription medication to be covered under the program, the medication must be:
    - prescribed for the treatment of a covered illness or injury
    - prescribed by a physician who is licensed to do so, and
    - a drug or device approved by the U.S. Food and Drug Administration (FDA) for the treatment of your condition. Prescription drugs purchased outside the United States are not covered.

  Please note that prescription benefits are administered by Express Scripts, and you should contact Express Scripts to learn whether your drug is covered. For a list of prescriptions that aren't covered, please see *What's Not Covered* section.
- private-duty nursing care, given on an outpatient basis by a licensed nurse for medical treatment of an injury or illness,
- psychologist services,
- pulmonary rehabilitation,
- radiation oncology therapy,

- TMJ treatment and surgery. Under no circumstances is adult orthodontia considered an allowable benefit for the treatment of TMJ unless the TMJ treatment is to treat an injury sustained as a result of domestic violence,
- tobacco cessation, including nicotine replacement therapy (NRT), (please see the *Medical Plan Highlights* in the beginning of this section for more details)
- voluntary sterilization (vasectomy or tubal ligation), and
- wigs due to loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury or an act of domestic violence, limited to $300 per wig, up to two wigs within any five-year period.

What's Not Covered

The Medical Plan does not cover any expenses incurred for services, supplies, medical care or treatment in connection with the following:

- services or supplies received before you or your eligible dependent were covered under the Medical Plan,
- services, supplies, confinement or treatment that is not considered medically necessary. For purposes of determining whether a service, supply, confinement, medical care or treatment is medically necessary, Claims Administrators may rely on its internal guidelines,
- supplies provided or services rendered by a psychologist of less than doctoral level licensure and education, or social workers of less than masters level licensure and education, or any provider who is not licensed to practice independently (without supervision),
- custodial care, regardless of who recommends, provides or directs the care, or whether or not the patient or another caregiver can be, or is being trained to care for himself or herself. Custodial care includes care that is intended to train or assist in personal hygiene or other activities of daily living or care that could be provided by a non-health care provider,
- services, supplies, medical care or treatment given by your immediate family, including your spouse, or your or your spouse's child, brother, sister, parent or grandparent,
- services and supplies that are considered Experimental or Investigational Service or unproven by the Medical Plan,
- occupational injury or sickness covered under a workers' compensation act or a similar law. This includes expenses or services for you or your covered dependent who had the option to be covered under a workers' compensation-type medical plan and did not elect coverage,
- court-ordered exams or treatment unless listed as covered under the Medical Plan,
- charges made by a hospital for confinement in a specialized area of the hospital. Those charges, if applicable, would be covered under benefits appropriate for a birthing center, hospice or skilled nursing care facility; not as hospital benefits,
- services or supplies received as a result of war, declared or undeclared, or international armed conflict,
- services or supplies received while you are incarcerated,
- services provided by volunteers or persons who do not normally charge for their services, or
- services and supplies for which you are not legally required to pay.

Other services that are not covered under this Medical Plan include:

- cranial molding helmets for cosmetic reasons
- abdominoplasty, unless patient was diagnosed as morbidly obese and has lost 100 pounds of weight. You must pre-certify this procedure with your health medical plan.
- alternative treatments, including acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health,
- benign gynecomastia (abnormal breast enlargement in males),
- chelation therapy, except to treat heavy metal poisoning,
- manipulation therapy considered to be for maintenance/preventive purposes,
- claim form completion, fees for copying or completing records, or missed appointments,
- contraceptive devices, except as provided under *Additional Covered Services and Supplies*,
- cosmetic surgery that is not medically necessary or treatment to primarily change appearance except for reconstructive surgery listed under breast reconstruction services in the *What's Covered* section or a service identified in the *Gender Affirming Care* section,
- ecological or environmental medicine, diagnosis and/or treatment,

- education, training and room and board while confined in an institution which is a school or other training institution, a place of rest, a place for the aged, or a nursing home,
- educational therapy,
- elective abortions,
- eyeglasses, contact lenses (other than following cataract surgery),
- foot care - foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for medically necessary foot care required as part of the treatment of diabetes and for participants with impaired circulation to the lower extremities,
- hearing aids batteries or the repair of hearing aids,
- herbal medicine, holistic or homeopathic care, including drugs,
- Non-abstinence based substance abuse treatment (such as methadone or suboxone) and nutritionally based substance abuse treatment is not covered except when medically necessary
- learning disability treatment,
- liposuction,
- malocclusion treatment, including surgical correction,
- medical marijuana,
- membership costs for health clubs, weight loss clinics and similar programs,
- organ or tissue donation expenses, unless the transplant recipient is covered under the Medical Plan and undergoing a qualified transplant procedure performed at a designated transplant facility,
- orthotics (inserts) for shoes,
- outpatient recreational therapy,
- over-the-counter medicines, other than Nicotine Replacement Therapy as provided through Virgin Pulse, the Wellness Program vendor,
- pastoral counseling services,
- personal convenience or comfort items (for example, TV, telephone, first aid kit, or exercise equipment),
- physician stand-by services,
- prescription drugs and products that are excluded:
    - photo-aged skin products, hair growth products, and injectable cosmetics such as Botox;
    - depigmentation products used for skin conditions requiring a bleaching agent;
    - erectile dysfunction medications (oral and injectable) for males and females unless medically necessary for the treatment of BH in males;
    - non-sedating antihistamines;
    - drugs used to suppress and control fat absorption unless medically necessary;
    - injectable allergens;
    - certain serums, toxoids, and vaccines;
    - dental and pediatric fluoride products;
    - certain compound medications;
    - over-the-counter equivalents and medications;
    - swabs;
    - homeopathic drugs;
    - peak flow meters;
    - ostomy supplies when obtained from Express Scripts (these supplies are covered only under the health plan benefit);
    - medications used for experimental* treatments and/or dosage regimens determined to be experimental*;
    - medications that do not require a physician's authorization by state or federal law; and
    - medications purchased outside the United States.
    - The nutritional supplement class contains more than infant formula, including the following (all of which are technically classified as OTC's, but pharmacies will process through Rx benefits when presented with a prescription from the patient's doctor):
        - Infant formula
        - Supplements for medical conditions, not infant formula though (i.e. nutritional therapy for those with phenylketonuria, impaired digestive disorders, certain metabolic disorders)
        - Medical foods (i.e. Ensure, Boost, vitamin preparations)

The above is not meant to be an exhaustive list. Please note that prescription benefits are administered by Express Scripts, and you should contact Express Scripts to learn whether your drug is covered. For a list of prescriptions that are covered, please see *What's Covered* section.

- private-duty nursing services while confined in a facility,
- reversal of sterilization,
- sensitivity training, educational training therapy or treatment for an education requirement,
- services for a surgical procedure to correct refraction errors of the eye and all related expenses,
- special foods, food supplements, liquid diets, diet medical plans or any related products, unless it is a nutritional supplement or infant formula dispensed by the pharmacy pursuant to a prescription from their prescriber.
- treatment of the teeth, gums or supporting structures, such as periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak, except for services listed as covered under *Oral Surgery/Dental Services*,
- TMJ splint,
- vitamin supplements that are classified by Express Scripts as over-the-counter drugs (other than vitamins that are considered "preventive care" under the Affordable Care Act), and
- wigs or toupees, hair transplants, hair weaving or any drug used in connection with baldness and hair loss other than that resulting from treatment of a malignancy or permanent loss of hair from an accidental injury or an act of domestic violence.

Domestic Violence

If you have been the victim of domestic violence, you may be eligible for treatment of your injury or medical condition even if the treatment or service is otherwise excluded by the Plan.

Making Claims

With the exception of mental health and alcohol and drug abuse benefits, 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:
    - get a claim form from Edward Jones or Anthem
    - complete your portion of the form
    - have the provider complete the provider portion of the form, and
    - send the form and bills to the address shown on your ID card. 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.

When Claims Must Be Filed

The *Claim, Appeal and Legal Information* section of this SPD contains detailed information about how and when to file a claim. Member submitted claims must be filed 12 months from the date of service.

Receiving Reimbursement

You will receive reimbursement after you have provided necessary proof of expense except in the following cases:

- if you have financial responsibility under a court order for a dependent's medical care, payments will be made directly to the provider of care
- if benefits are paid directly to Network providers, and
- if you request that payments be made directly to a provider when you complete the claim form.

You will receive a statement or Explanation of Benefits (EOB) to explain how your claim was paid. If any of your claim is denied, in whole or in part, you will receive a written explanation.

Appealing a Claim

The *Claim, Appeal and Legal Information* section of this handbook contains detailed information about how to appeal a denied claim. A first level appeal must be hand written and submitted within 180 days of adverse determination.

For More Information

For more information regarding eligibility, COBRA continuation of coverage, administrative information about the Medical Plan and your rights as a participant in the Edward D. Jones & Co. Employee Health & Welfare Program, please see the *Eligibility and Electing Benefits, Leaving the Plan*, or the *Claim, Appeal and Legal Information* sections respectively.