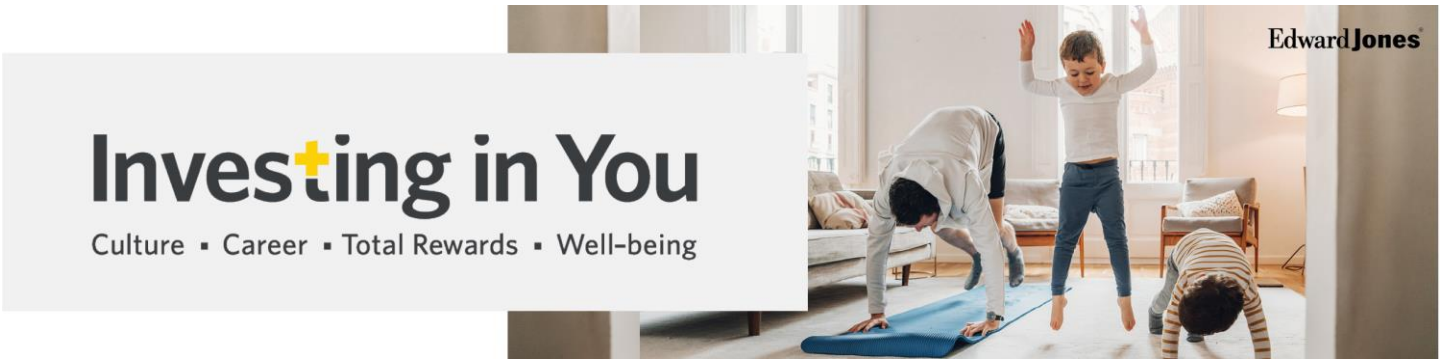

2024 Coverage Details – Client Support Team & Home Office

The following charts provide information about your benefit coverages, including an overview of key plan features. For full details, see the Investing in You benefits website: www.edwardjonesbenefits.com.

Medical Benefits (Network Provider: Anthem Blue Cross)				
	GOLD Medical Plan		**SILVER** Medical Plan	
Plan Features	**Network Provider**	**Out-of-Network Provider[1]**	**Network Provider**	**Out-of-Network Provider[1]**
Annual Deductible	**$2,000 per person, $4,000 per family**	**$4,000 per person, $8,000 per family**	**$4,000 per person, $8,000 per family**	**$6,000 per person, $12,000 per family**
	Applies to Medical, Rx and Behavioral Health expenses only. Dental and Vision expenses do not apply to deductible.			
Deductible Procedure	For dependent coverage tiers: **Gold:** One person or a combination of family members must meet the full family deductible before the plan starts paying 80% on family's claims. **Silver:** One person may satisfy the per-person deductible; then the plan will begin paying 80% on that member's claims.			
Maximum you pay including annual deductible	20% coinsurance after deductible $4,000 per person/ $8,000 per family Out-of-Pocket (OOP)	40% coinsurance after deductible $7,000 per person/ $14,000 per family Out-of-Pocket (OOP)	20% coinsurance after deductible $6,000 per person/ $12,000 per family Out-of-Pocket (OOP)	40% coinsurance after deductible $8,000 per person/ $16,000 per family Out-of-Pocket (OOP)

Both medical plans cover these services in the same manner:			
Your Plan Covers:		**In-Network Provider**	**Out-of-Network Provider[1]**
Medical	Preventive Care for Adults (including one annual routine physical and well-woman exam, mammogram, breast pumps, immunizations, colonoscopy, wellness eye exam, flu vaccine, prostate screening and BRCA testing)	100%; no deductible	40% coinsurance after deductible
	Preventive Care for Children (including immunizations)	100%; no deductible	40% coinsurance after deductible

Both medical plans cover these services in the same manner:			
Your Plan Covers:		**In-Network Provider**	**Out-of-Network Provider[1]**
	Physician's Office Visit/Virtual Doctor Visit (medical diagnosis and treatment)	20% coinsurance after deductible	40% coinsurance after deductible
	Lab/X-ray	20% coinsurance after deductible	40% coinsurance after deductible
	In-hospital Medical Care[2]	20% coinsurance after deductible	40% coinsurance after deductible
	Emergency Room Treatment[3]	20% coinsurance after deductible	40% coinsurance after deductible
	Urgent Care Center/Convenience Care Clinic/ Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
	Behavioral Health	20% coinsurance after deductible	40% coinsurance after deductible
	Prenatal and Maternity Care/Newborn Care[4]	20% coinsurance after deductible	40% coinsurance after deductible
	Manipulative Therapy[5] (Chiropractic)	20% coinsurance after deductible	40% coinsurance after deductible
	Physical, Speech, Occupational Therapy[6]	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Medications	Administered by Express Scripts: Retail Pharmacy – Maximum 30-day supply available for generic and brand drugs Through Mail Service – Up to 90-day supply available for generic and brand drugs	Brand[7] and generic covered at 80% after deductible (Women's prescription contraceptives and cancer prevention drugs for women at high risk covered 100% before deductible.)	Not applicable
	Maintenance Medications at Retail: You'll pay more if you don't switch to mail order after the third refill at a retail pharmacy.	If you don't switch to mail order: You will pay the full cost of the drug at 100% before and after your deductible is met. None of the penalty costs will be applied toward your deductible or out-of-pocket.	Not applicable
	Lifetime Maximum Benefit	Unlimited	Unlimited

1 Charges for out-of-network providers are subject to allowed limits. The patient is responsible for amounts billed by provider that exceed the allowed amount.

2 Precertification is required for all inpatient hospital care.

3 In an actual emergency, the network coverage level applies (up to allowed limit) regardless of the provider you use for emergency care. If you use an emergency room for non-emergency care, the expense is not covered.

4 Maternity benefit level applies only to OB/GYN services. Lab, ultrasound, etc., are covered under the Lab/X-ray benefit. For labor/ delivery, refer to In-hospital Medical Care. Nursery care for well newborns is covered under the mother's in-hospital deductible.

5 Maximum 35 visits per year.

6 Maximum 20 visits per year per therapy.

7 If patient requests brand drugs when their doctor approves a generic, the Plan only covers cost of generic drug.

GOLD Medical Plan Per Pay Period Rates for Client Support Teams and Home Office Associates			
Coverage	**In-Network Deductible**	**Full Rate[2]**	**Fully Discounted Rate[3]**
Associate	$2,000	$61.08	$30.31
Associate + Spouse/ Domestic Partner[3]	$4,000 per family[4]	$179.05	$117.52
Associate + Child(ren)		$120.41	$58.87
Associate + Family[3]		$210.58	$149.04

The **Silver** medical plan option is for associates who are willing to take on a higher deductible in exchange for a lower premium. Visit the *Investing in You* site to access a plan decision support tool that will help you determine if this is a good fit for you.

SILVER Medical Plan Per Pay Period Rates for Client Support Teams and Home Office Associates			
Coverage	**In-Network Deductible**	**Full Rate[2]**	**Fully Discounted Rate[3]**
Associate	$4,000	$47.33	$16.56
Associate + Spouse/ Domestic Partner[3]	$4,000 per person, $8,000 per family[5]	$148.30	$86.76
Associate + Child(ren)		$96.19	$34.65
Associate + Family[3]		$166.75	$105.22

1 If you or your enrolled adult dependent is a tobacco user (defined as using any form of tobacco more than 12 times in the last 12 months), add $10 per pay period per tobacco user (up to $20 per pay period maximum).

2 Fully discounted rate is the rate you'll pay if you and your spouse/domestic partner earn the maximum Wellness Program incentives.

3 If you enroll a spouse/domestic partner who has coverage available through his/her employer's medical plan, add $46.15 per pay period to the rate shown.

4 Gold Plan: One person or a combination of family members must satisfy the full family deductible; then the plan will begin paying 80% on family's claims.

5 Silver Plan: One family member may satisfy the per-person deductible; then the plan will begin paying on that member's claims.

Associates enrolled in the Edward Jones Medical Plan after January 1, 2023, can earn up to $800* toward their 2024 medical plan premium. Covered spouses/domestic partners also can earn up to $800* toward the medical plan premium.

Monthly Wellness Program Incentives	
Activity	**Maximum Per Pay Period Reward of:**
MyPulse Health Assessment	$3.85 per person; $7.69 per family
Biometric Screening Measures	$15.38 per person; $30.77 per family
Lifestyle Activities	$11.54 per person $23.08 per family

Note: Associates enrolled in Associate + Child(ren) coverage without a spouse/domestic partner enrolled in the medical plan will automatically earn an additional $800* for their eldest, enrolled child.

Alternative Means for Discounts: Incentives 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 have an opportunity to earn the same reward by different means. Contact Virgin Pulse at 833-880-4209 to speak to a health coach. This health coach will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

For Newly Enrolled Dependents Only

If you enroll a dependent (spouse/domestic partner or child) in the Edward Jones Medical Plan for the first time during Open Enrollment, you will be required to submit documents that verify that your dependent is eligible for medical coverage, as directed by the Plan. In January, you'll receive a packet mailed to your home address from Mercer, an Edward Jones approved partner administering the program for us, with all of the information you'll need to complete the verification process. Failure to prove your dependent meets the eligibility criteria will result in the dependent being terminated from the Medical Plan.

Dental Plan (Network Provider: Delta Dental)		
Benefit	**Premium Dental Plan**	**Basic Dental Plan**
Preventive care (twice a year cleaning, checkup, X-rays)	100%, no deductible	100%, no deductible
Annual deductible for treatment	$75 per person/ $150 per family	$50 per person (no family limit)
Basic services (fillings, periodontics, root canals, simple and surgical extractions)	80% after deductible	50% after deductible
Major services (bridges and dentures, crowns, oral surgery)	50% after deductible	50% after deductible
Maximum annual benefit payable for all services, other than preventive care	$2,000 per person	$1,000 per person
Orthodontia for children under age 19. Note: The orthodontia benefit is paid quarterly as the treatment plan progresses. If you drop Premium coverage during the course of orthodontia treatment, you won't receive the full $2,000 benefit.	50% after deductible, lifetime maximum of $2,000 per child	Not covered
Coverage	**Per Pay Period Rate**	
Associate Only	$19.17	$11.11
Associate Plus One Child	$32.97	$18.73
Associate Plus Two Children	$47.39	$26.36
Associate Plus Three Children	$61.82	$33.99
Associate Plus Four or More Children	$76.24	$41.64
Associate Plus Spouse/Domestic Partner Only	$38.40	$22.22
Associate Plus Spouse/Domestic Partner and One Child	$51.67	$29.85
Associate Plus Spouse/Domestic Partner and Two Children	$65.94	$37.47
Associate Plus Spouse/Domestic Partner and Three Children	$80.36	$45.10
Associate Plus Spouse/Domestic Partner and Four or More Children	$94.79	$52.72

Vision Plan (Network Provider: VSP)			
Benefit	**Description**	**Co-Pay**	**Frequency**
Well Vision Exam	Focuses on your eyes and overall wellness	$0	Every calendar year
Contact Fitting	Contact lens exam (fitting and evaluation)	$60	Every calendar year
Prescription Glasses Frame	$200 allowance 20% off any amount over allowance	$35 Included in Prescription Glasses co-pay	Every other calendar year
Lenses	Single vision, lined bifocal, lined trifocal	Included in Prescription Glasses co-pay	Every calendar year
Lens Options	• Polycarbonate lenses for children	$0	Every calendar year
	• Standard progressive lenses	$0	
	• Premium progressive lenses	$95 - $105	
	• Custom progressive lenses	$150 - $175	
	Average 20% - 25% off other lens options		
Contacts (instead of glasses)	• $200 allowance for contacts	Contact lens exam (fitting and evaluation), covered in full after copay	Every calendar year
Extra Savings and Discounts	Glasses and Sunglasses • 30% off additional glasses and sunglasses from the same VSP doctor on the same day as your exam • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision exam Laser Vision Correction • Average 15% off the regular price or 5% off the promotional		
Coverage	**Per Pay Period Rate**		
Single	$2.79		
Dual	$5.63		
Family	$9.06		

Note: Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit www.vsp.com for details.

Supplemental Life Insurance Options

Rates are based on age and tobacco status. Find the correct rate (tobacco user/non-tobacco user, age) and multiply it by the number of thousands of coverage. Your purchase limit is up to $2.0 million.

Example: Non-tobacco user, age 42, requests $200,000 in coverage. Rate is $.041 X 200 = $8.20/ month.

Supplemental Life Insurance Associate		
Age	**Non-Tobacco User**	**Tobacco User**
Monthly Rate per $1,000		
Under 30	$.015	$.019
30 - 34	$.018	$.025
35 - 39	$.026	$.034
40 - 44	$.041	$.052
45 - 49	$.066	$.083
50 - 54	$.108	$.137
55 - 59	$.171	$.216
60 - 64	$.228	$.286
65 - 69	$.361	$.457
70 and over	$.716	$.800

Supplemental Life Insurance Spouse/ Domestic Partner	
Coverage Amount[1]	**Per Pay Period Rate**
$10,000	$0.49
$25,000	$1.23
$50,000	$2.46
$100,000	$4.95

[1] May require evidence of insurability

If you purchase coverage for children, you'll pay the rate shown on the table below no matter how many children you have. Coverage does not require evidence of insurability.

Supplemental Life Insurance Child(ren)	
Coverage Amount	**Per Pay Period Rate**
$5,000	$0.29
$10,000	$0.57
$25,000	$1.46

Supplemental Accidental Death & Dismemberment Options

You may purchase coverage which insures your own life in multiples of $25,000 to $100,000, then multiples of $100,000 to $1 million. Coverage does not require evidence of insurability. Your family members' lives are insured for a portion of the associate benefit.

Supplemental Accidental Death & Dismemberment (AD&D)	
Plan	**Per Pay Period Rate**
Associate Only	$.0042 per $1,000
Family Plan	$.0069 per $1,000

This is intended to be a summary. For details on your coverage, please refer to the Summary Plan Description and other benefit information provided on www.edwardjonesbenefits.com.