

# 2023 Rates and Coverage Details – Branch Support Team & Home Office

The following charts provide information about your benefit coverages, including an overview of key plan features, rates and providers. For full details, see the Investing in You benefits website: [www.edwardjonesbenefits.com](http://www.edwardjonesbenefits.com).

Medical Benefits (Network Provider: Anthem Blue Cross)				
	PREMIUM Medical Plan		PLATINUM Medical Plan	
Plan Features	Network Provider	Out-of-Network Provider¹	Network Provider	Out-of-Network Provider¹
Annual Deductible	\$3,850 per person, \$7,750 maximum per family (Applies to Medical, Rx and Behavioral Health expenses only. Dental and Vision expenses do not apply to deductible.)		\$4,850 per person, \$9,750 maximum 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: One family member may satisfy the per-person deductible; then the plan will begin paying on that member's claims.			
Maximum you pay in addition to annual deductible	No additional cost after deductible	\$2,000 per person/ \$4,000 per family	No additional cost after deductible	\$2,000 per person/ \$4,000 per family

Both medical plans cover these services in the same manner:			
Your Plan Covers:		In-Network Provider	Out-of-Network Provider <sup>1</sup>
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	60% after deductible
	Preventive Care for Children (including immunizations)	100%; no deductible	60% after deductible
	Physician's Office Visit/Virtual Doctor Visit (medical diagnosis and treatment)	100% after deductible	60% after deductible
	Lab/X-ray	100% after deductible	60% after deductible
	In-hospital Medical Care <sup>2</sup>	100% after deductible	60% after deductible
	Emergency Room Treatment <sup>3</sup>	100% after deductible	60% after deductible
	Urgent Care Center/Convenience Care Clinic/ Outpatient Surgery	100% after deductible	60% after deductible
	Behavioral Health	100% after deductible	60% after deductible
	Prenatal and Maternity Care/Newborn Care <sup>4</sup>	100% after deductible	60% after deductible
	Manipulative Therapy <sup>5</sup> (Chiropractic)	100% after deductible	60% after deductible

	Physical, Speech, Occupational Therapy <sup>6</sup>	100% after deductible	60% 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 <sup>7</sup> and generic covered 100% 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: Before deductible: You'll pay the full cost of the drug, but only 20% of the cost will be applied toward your deductible and your out-of-pocket maximum. After deductible: The Plan will pay only 80% of the cost of a generic or brand drug instead of 100% (\$15 minimum).	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.

### Premium Medical Plan Per Pay Period Rates for Branch Support Teams and Homes Office Associates

Coverage	Deductible	Full Rate <sup>1</sup>	Fully Discounted Rate <sup>2</sup>
Associate	\$3,850	\$57.73	\$26.96
Associate + Spouse/Domestic Partner <sup>3</sup>	\$3,850 per person, \$7,750 maximum per family <sup>4</sup>	\$169.25	\$107.71
Associate + Child(ren) <sup>3</sup>		\$113.82	\$52.28
Associate + Family <sup>3</sup>		\$199.04	\$137.50

The Platinum 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 plan is a good fit for you.

Platinum Medical Plan Per Pay Period Rates for Branch Support Teams and Homes Office Associates			
Coverage	Deductible	Full Rate <sup>1</sup>	Fully Discounted Rate <sup>2</sup>
Associate	\$4,850	\$44.73	\$13.96
Associate + Spouse/Domestic Partner <sup>3</sup>	\$4,850 per person, \$9,750 maximum per family <sup>4</sup>	\$140.17	\$78.64
Associate + Child(ren) <sup>3</sup>		\$90.92	\$29.38
Associate + Family <sup>3</sup>		\$157.62	\$96.08

<sup>1</sup> 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).

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

<sup>3</sup> 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.

<sup>4</sup> 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, 2022, can earn up to \$800\* toward their 2023 medical plan premium. Covered spouses/domestic partners also can earn up to \$800\* toward the medical plan premium.

Per Pay Period 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	\$22.81	\$13.22
Associate Plus One Child	\$39.22	\$22.29
Associate Plus Two Children	\$56.38	\$31.36
Associate Plus Three Children	\$73.54	\$40.43
Associate Plus Four or More Children	\$90.70	\$49.53
Associate Plus Spouse Only	\$45.67	\$26.43
Associate Plus Spouse and One Child	\$61.47	\$35.51
Associate Plus Spouse and Two Children	\$78.44	\$44.57
Associate Plus Spouse and Three Children	\$95.60	\$53.65
Associate Plus Spouse and Four or More Children	\$112.76	\$62.71

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	\$175 allowance (\$195 allowance on certain brands) 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	\$55	
	• Premium progressive lenses	\$95 - \$105	
	• Custom progressive lenses	\$150 - \$175	
	Average 20% - 25% off other lens options		
Contacts (instead of glasses)	• \$175 allowance for contacts	Contact lens exam (fitting and e valuation), 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 WellVision exam  Laser Vision Correction • Average 15% off the regular price or 5% off the promotional		
Coverage	Per Pay Period Rate		
Single	\$3.95		
Dual	\$7.98		
Family	\$12.85		

**Note:** Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit [www.vsp.com](http://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 the lesser of \$2.0 million or 10 times your annual earnings.

**Example:** Non-tobacco user, age 42, requests \$200,000 in coverage. Rate is \$.041 X 200 = \$8.20/month. To arrive at a biweekly rate, multiply the monthly premium by 12 then divide by 26 paychecks (equal to \$3.78 in this example).

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 <sup>1</sup>	Per Pay Period Rate
\$10,000	\$0.49
\$25,000	\$1.23
\$50,000	\$2.46
\$100,000	\$4.95

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](http://www.edwardjonesbenefits.com).

<sup>1</sup> May require evidence of insurability