2023 Coverage Details – COBRA – Financial Advisors & General Partners

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)				
	PREMIUM Medical Plan		**PLATINUM** Medical Plan	
Plan Features	Network Provider	Out-of-Network Provider[1]	Network Provider	Out-of-Network Provider[1]
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[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	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[2]	100% after deductible	60% after deductible
	Emergency Room Treatment[3]	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[4]	100% after deductible	60% after deductible
	Manipulative Therapy[5] (Chiropractic)	100% after deductible	60% after deductible
	Physical, Speech, Occupational Therapy[6]	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[7] 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.

COBRA Medical Plan Monthly Rates

Coverage	Premium Medical Plan	Platinum Medical Plan
Associate	$584.51	$555.97
Associate + Spouse/Domestic Partner	$1,315.04	$1,250.69
Associate + Child(ren)	$1,022.81	$972.76
Associate + Family	$1,870.37	$1,778.90

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.

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
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	**Monthly Rate**	
Associate Only	$50.41	$29.22
Associate Plus One Child	$86.68	$49.26
Associate Plus Two Children	$124.59	$69.31
Associate Plus Three Children	$162.52	$89.35
Associate Plus Four or More Children	$200.44	$109.46
Associate Plus Spouse Only	$100.94	$58.42
Associate Plus Spouse and One Child	$135.84	$78.47
Associate Plus Spouse and Two Children	$173.35	$98.50
Associate Plus Spouse and Three Children	$211.27	$118.57
Associate Plus Spouse and Four or More Children	$249.20	$138.60

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	**Monthly Rate**		
Single	$8.73		
Dual	$17.63		
Family	$28.40		

Note: Coverage with a retail chain affiliate may be different, visit www.vsp.com for details.