

2023 Coverage Details – COBRA – Branch 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)				
	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 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	\$615.84	\$584.10
Associate + Spouse/Domestic Partner	\$1,388.19	\$1,316.78
Associate + Child(ren)	\$1,063.28	\$1,007.75
Associate + Family	\$2,005.51	\$1,903.95

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 deductible)
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 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 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.